Screen Date Early and Periodic		West Virginia Department of Health and Human Resources creening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Prever				ventive Health Screen		Newborn to 1 Week Form	
Name					DOB		Age	Sex:	□М □F
Weight	Length	Weight for Length	HC	Pulse	BP (optional)	Resp Tem	ıp	_ Pulse Ox (<i>optional</i>)	
Allergies □ N	NKDA								
Current meds	s □ None								
☐ Foster child	d			□ Chil	d with special health care needs_				
Accompanie	d by □ Parent □ G	Grandparent □ Foster parent □ F	oster organiz	ration					
Complications	ges	Maternal labs	Social Lan	ental Surveillance (guage and Self–hel	✓ Check those that apply) p □ Child has periods of	General Appearance Skin	ce □N □Ab	ormal, Abn=Abnormal) on	
Birth history		ischarge weight	wakefulness ☐ Child looks at and studies you when awake ☐ Child looks in your eyes when being held ☐ Child calms when picked up ☐ Child responds differently to soothing touch alerting touch Verbal Language ☐ Child communicates discomfort through crying, facial expressions and body movements ☐ Child moves or calms to your voice			Neurological Reflexes Head Fontanelles	□ N □ Abn		
		□ Fail □ Pending □ Retest				or Neck Eyes Red Reflex	□N □Ab □N □Ab	onon on	
		d	Gross Motor ☐ Child moves in response to visual or auditory stimuli ☐ Child moves arms and legs symmetrically and reflexively when startled ☐ Child lifts head briefly when on stomach and can turn it to the side Fine Motor ☐ Child keeps hands in fist ☐ Child automatically grasps others' fingers or objects Concerns and/or questions			Ears Nose	□N □Ab	on	
Concerns and	d/or questions					Oral Cavity/Throat Lung	□N □Ab	IN	
•	chosocial Histor family's living situatio	r y n?				Heart Pulses Abdomen	□N □Ab □N □Ab		
		to take care of your baby (crib, car		cators (✓ Check th		Umbilical cord Genitalia Back	□N □Ab □N □Ab □N □Ab	on onon	
Do you have concerns about meeting basic family needs daily and/o monthly (food, housing, heat, etc.)? ☐ Yes ☐ No			Child exposed to □ Cigarettes □ E-Cigarettes □ Alcohol □ Drugs (prescription or otherwise)			Hips Extremities Jaundice □ Yes		□ Abn □ Abn	
				lotted on growth cha		_	Possible Signs of Abuse ☐ Yes ☐ No Concerns and/or questions		
,	, .	ng outside home? ☐ Yes ☐ No	Do you thin Oral Health	k your child sees oka	ay? □ Yes □ No				
□ None □ S	ress are you and you	□ Severe		ce: □ Public □ W	′ell □ Tested				
What kind of stress? (✓ Check those that apply)			Nutrition/S	ieep					

Frequency_

☐ Breastfeeding - Frequency _

☐ Formula _

□ Normal elimination_

☐ Place on back to sleep_

Concerns and/or questions_

☐ Bottle feeding - Amount_____

☐ Relationships (partner, family and/or friends) ☐ School/work

☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical,

support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance ☐ Other__

emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of



Screen Date		Newborn to 1 Week Form, F	Page 2
Name	Di	OB Age Sex: □ M	ΠF
Anticipatory Guidance	Questions/Concerns/Notes	Plan of Care	
(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)		Assessment	
Social Determinants of Health		Immunizations	VOUC
☐ Living situation and food security☐ Environmental tobacco exposure		□ UTD □ Given, see immunization record □ Entered into W\	VSIIS
☐ Intimate partner violence ☐ Maternal alcohol and substance use		Labs	
☐ Family Support ☐ Parent(s)-newborn relationship			
Parental/Family Health and Well-being			
☐ Maternal health and nutrition		Referrals Developmental	
☐ Transitioning home		Other	• • • • • • • • • • • • • • • • • • • •
☐ Sibling adjustments/relationships		☐ Right from the Start (RFTS)1-800-642-9704	
Newborn Behavior and Care		□ Birth to Three (BTT) 1-800-642-9704	
☐ Baby care (infant supplies, skin, and cord care)			
☐ Illness prevention (hand washing, outings and sun protection)		1-800-642-9704	
□ Calming your baby		□ Women, Infants and Children (WIC)1-304-558-0030	
☐ Early brain development (singing, talking and reading to child)			
☐ Emergency care			
Nutrition and Feeding		Prior Authorizations	
☐ General guidance on feeding		For treatment plans requiring authorization, please cor page 3. Contact a HealthCheck Regional Program Special	
☐ Breastfeeding guidance		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck	ist ioi
☐ Formula feeding guidance		assistance at 1-000-042-5704 of diffin.wv.gov/fleathicfleck	
Safety			
☐ Car seat safety		Follow Un/Next Visit □ 1 month of age □ 2 months of age	
☐ Heatstroke prevention		Follow Up/Next Visit □ 1 month of age □ 2 months of age	
☐ Safe sleep		☐ Other	
□ Pets			
☐ Safe home environment			
□ Other		□ Screen has been reviewed and is complete	
		Please Print Name of Facility or Clinician	

Signature of Clinician/Title

Screen Date Early and Periodic			West Virginia Department of Health and Human Resources Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen					een	By 1 Month Form	
Name					DOB		Ag	ge	Sex: 🗆 M	□F
Weight	Length	Weight for Length	HC	Pulse	BP (optional)	Resp	Temp	Pulse Ox (op	otional)	
Allergies □ Nh	KDA									
Current meds	□ None									
☐ Foster child				□ Chil	d with special health care n	eeds				
Accompanied	by □ Parent □ G	Grandparent □ Foster parent □ F	oster organiz	zation						
Newborn metals Newborn bilirub Newborn critica Results in ch Newborn hearir Results in ch Recent injuries, hospitalizations	Depolic screen NL Din screen Pass Dild's record	ischarge weight	*Positive s *If positive Postnatal Feelings o Little intere Not at al Nearly e Feeling do	screen = numbered e, see Periodicity So Depression Scale (I ever the past 2 week st or pleasure in doir	s: (√ Check one for each que things ☐ More than ½ the days(rgh Do Do Do W	Teneral Health If Growth plotted on growth To you think your child sees To you think your child hears Tral Health Train He	okay?	quency	
Concerns and/or questions			Developmental Developmental Surveillance (✓ Check those that apply)				☐ Formula			
Social/Psychosocial History What is your family's living situation?		Social Language and Self-help □ Child looks at you and follows you with his/her eyes □ Child has self-comforting behaviors, such as bringing hands to mouth □ Child becomes fussy when bored □ Child calms when picked up or spoken to			d follows □ rs, such □	□ Sleeps 3 to 4 hours at a time □ Can stay awake for 1 hour or longer Concerns and/or questions				
Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No					□ Child					
		ting basic family needs daily and/or ? ☐ Yes ☐ No	environment (excessive crying, tremors, excessive startles) ☐ Child has different types of cries for hunger and tiredness Gross Motor ☐ Child moves both arms and legs together			s *T	*See Periodicity Schedule for Risk Factors *Tuberculosis Risk Low risk High risk			
Who do you co	o do you contact for help and/or support?			□ Child can hold chin up when on stomach Fine Motor □ Child can open fingers slightly when at rest						
Are you and/or your partner working outside home? Yes No Child care plans? How much stress are you and your family under now?			Concerns and/or questions							

Risk Indicators (✓ Check those that apply)

☐ Drugs (prescription or otherwise)

Concerns and/or questions

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

□ None □ Slight □ Moderate □ Severe

What kind of stress? (✓ Check those that apply)

insurance ☐ Other_

☐ Relationships (partner, family and/or friends) ☐ School/work

☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical,

support/help ☐ Financial/money ☐ Emotional loss ☐ Health

emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of



Screen Date	By 1 Month Form, Page 2

Physical Examin	nation (N=Normal, Abn=Abnormal)	Anticipatory Guidance	Plan of Care
General Appearance	□ N □ Abn	(Consult Bright Futures, Fourth Edition for further information	Assessment □ Well Child □ Other Diagnosis
Skin	□ N □ Abn	https://brightfutures.aap.org)	
Neurological	□ N □ Abn		
Reflexes	□ N □ Abn	Social Determinants of Health	Immunizations
Head	□ N □ Abn	☐ Living situation and food security	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Fontanelles	□ N □ Abn	☐ Environmental tobacco exposure	
Neck	□ N □ Abn	Li Damphess and mold	
Eyes	□ N □ Abn		Labs
Red Reflex	□ N □ Abn	— □ Pesticides — □ Intimate partner violence	☐ TB skin test (if high risk) ☐ Other
Ears	□ N □ Abn	— ☐ Maternal alcohol and substance abuse	Li Ottlei
Nose	□ N □ Abn	□ Family support/help	
Oral Cavity/Throat	□ N □ Abn	— — — Family supportment	
Lung	□ N □ Abn	Parental/Family Health and Well-being	Referrals ☐ Maternal depression - Help4WV.com/1-844-435-7498
Heart	□ N □ Abn	□ Postpartum checkup	□ Developmental
Pulses	□ N □ Abn	☐ Maternal depression	□ Other
Abdomen	□ N □ Abn	☐ Family relationships	
Genitalia	□ N □ Abn		☐ Right from the Start (RFTS) 1-800-642-9704
Back	□ N □ Abn	Infant Behavior and Development	☐ Birth to Three (BTT) 1-800-642-9704
Hips	□ N □ Abn	Li Sieeping and waking	☐ Children with Special HealthCare Needs (CSHCN)
Extremities	□ N □ Abn	☐ Fussiness and attachment	1-800-642-9704
LAUGITIUGS		☐ Media (distract from child's care)	☐ Women, Infants and Children (WIC) 1-304-558-0030
Signs of Abuse	□ Yes □ No	□ Playtime	
Concerns and/or que		☐ Medical home after hours support	Prior Authorizations
Corrodino ana/or que			For treatment plans requiring authorization, please complet
		Nutrition and Feeding	page 3. Contact a HealthCheck Regional Program Specialist for
		☐ Feeding plans and choices	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
		☐ General guidance on feeding	
		☐ Breastfeeding guidance	
		☐ Formula feeding guidance	Follow Up/Next Visit □ 2 months of age
		Safety	□ Other
		☐ Car seat safety	_ 0
		□ Safe sleep	
	 	☐ Preventing falls (changing table, couch, bed)	
		☐ Emergency care (CPR)	☐ Screen has been reviewed and is complete
		□ Other	
			-
			Please Print Name of Facility or Clinician
			-
			Signature of Clinician/Title

DOB_

Sex: □ M □ F

Screen Date	West Virginia Department of Health and Human Resources Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen
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2	м	n	nth	F٢	rm

Name	DOB		Age	Sex: □ M □ F
Weight Length Weight for Length	HC Pulse BP (<i>optional</i>)	Resp T	empP	Pulse Ox (optional)
Allergies NKDA				
Current meds None				
□ Foster child	☐ Child with special health o	care needs		
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ F	oster organization	□ Other _		
Medical History □ Initial screen □ Periodic screen	Maternal Depression/Patient Health Questionnaire *Positive screen = numbered responses 3 or grea *If positive, see Periodicity Schedule for link to Ed	ter ☐ Breastfeeding	g - Frequency	Frequency
Newborn metabolic screen □ NL □ Results in child's record Newborn hearing screen □ Pass □ Fail □ Retest □ Results in child's record	Postnatal Depression Scale (EPDS) Feelings over the past 2 weeks: (✓ Check one for e Little interest or pleasure in doing things □ Not at all □ Several days(1) □ More than ½ the	each question) ☐ Normal elimin ☐ Normal sleepi	nation ning patterns	
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	☐ Nearly every day(3) Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days(1) ☐ More than ½ the ☐ Nearly every day(3)	☐ Sleeps 3 to 4 Concerns and/or	hours at a time	
☐ Family health history reviewed		Physical Eva	amination (N=Norma	ol Ahn-Ahnormal)
Concerns and/or questions	Developmental Developmental Surveillance (✓ Check those that ap Social Language and Self-help □ Child smiles res	ply) General Appeara	rance □ N □ Abn _	ai, Abri-Abrioffiai)
Social/Psychosocial History What is your family's living situation?	☐ Child makes sounds that let you know if he/she is he Verbal Language (Expressive and Receptive) ☐ Checooing sounds Gross Motor ☐ Child lifts head and chest when on second sounds	nappy Neurological Reflexes Head	□ N □ Abn _ □ N □ Abn _ □ N □ Abn _	
Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No	keeps head steady when held in sitting position Fine Motor □ Child can open and shut hands □ Ch bring hands together	Red Reflex	□N □Abn _ □N □Abn _	
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? Yes No	Concerns and/or questions	Ocular Alignmer Ears Nose	nt □N□Abn _ □N□Abn _	
Who do you contact for help and/or support?	Risk Indicators (✓ Check those that apply) Child exposed to □ Cigarettes □ E-Cigarettes □	Oral Cavity/Thro Alcohol Lung	oat □N □Abn_	
Are you and/or your partner working outside home? ☐ Yes ☐ No Child care plans?	☐ Drugs (prescription or otherwise)	Heart Pulses	□ N □ Abn _	
How much stress are you and your family under now? □ None □ Slight □ Moderate □ Sever What kind of stress? (✓ Check those that apply) □ Relationships (partner, family and/or friends) □ School/work □ Child care □ Drugs □ Alcohol □ Violence/abuse (physical, emotional and/or sexual) □ Family member incarcerated □ Lack of support/help □ Financial/money □ Emotional loss □ Health insurance □ Other_	General Health ☐ Growth plotted on growth chart Do you think your child sees okay? ☐ Yes ☐ No Do you think your child hears okay? ☐ Yes ☐ No Oral Health Water source: ☐ Public ☐ Well ☐ Tested	Abdomen Genitalia Back Hips Extremities Signs of Abuse	□ N □ Abn _	
		Continue on	page 2	

reen Date		2 Month Form, Page
lame	DOB	Age Sex: □ M □
Anticipatory Guidance	Questions/Concerns/Notes	Plan of Care
(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)		Assessment
Social Determinants of Health		Immunizations
☐ Living situation and food security		□ UTD □ Given, see immunization record □ Entered into WVSII
☐ Family support		
□ Child care		
Parental/Family Health and Well-being		Labs
□ Postpartum checkup		
□ Depression		
☐ Sibling relationships		
a cibiling rotationships		Referrals □ Maternal depression - Help4WV.com/1-844-435-7498
Infant Behavior and Development		☐ Developmental
□ Parent - infant relationship		□ Other □
□ Parent - infant communication		
□ Sleeping		☐ Right from the Start (RFTS) 1-800-642-9704
□ Media		☐ Birth to Three (BTT) 1-800-642-9704
□ Playtime		☐ Children with Special HealthCare Needs (CSHCN)
□ Fussiness		1-800-642-9704
		☐ Women, Infants and Children (WIC) 1-304-558-0030
Nutrition and Feeding		
☐ General guidance on feeding and delaying solid foods		
☐ Hunger and satiety cues		Prior Authorizations
☐ Breastfeeding guidance		For treatment plans requiring authorization, please comple
☐ Formula-feeding guidance		page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
Safety		
☐ Car seat safety		
□ Safe sleep		Follow Up/Next Visit □ 4 months of age
☐ Safe home environment (burns, drowning, and falls)		□ Other
□ Other		
		☐ Screen has been reviewed and is complete
	_	Please Print Name of Facility or Clinician

Signature of Clinician/Title

Screen Date		Early and Periodic So			of Health and Human Re nt (EPSDT) HealthChecl		entive Health Scree	4 Month F	Form	
Name					DOB		Age	e Sex: 🗆 M	ΠF	
Weight	Length	Weight for Length	HC F	Pulse	BP (optional)	Resp	Temp	Pulse Ox (optional)		
Allergies □ N	KDA			· · · · · · · · · · · · · · · · · · ·						
Current meds	□ None			 		· · · · · · · · · · · · · · · · · · ·				
☐ Foster child			,	□ Child wit	h special health care needs	i				
Accompanied	by □ Parent □ G	Grandparent □ Foster parent □ F	oster organization			□	l Other			
	n ☐ Periodic s	es, visits to other providers and/or	*Positive screen = *If positive, see Po Postnatal Depress Feelings over the	numbered resperiodicity Sched sion Scale (EPDS past 2 weeks: (v	Check one for each quest	☐ Grow Do you Do you	think your child hears	hart okay? □ Yes □ No okay? □ Yes □ No		
Concerns and/	or questions		□ Nearly every day(3) Feeling down, depressed, or h □ Not at all □ Several days(□ Nearly every day(3) Concerns and/or questions		s(1) ☐ More than ½ the days(2)	Nutritio ☐ Breas ☐ Bottle ☐ Form ☐ Juice	n/Sleep stfeeding - Frequency e feeding - Amount ula Uwater started solid foods	ncy t Frequency		
Do you have th	ne things you need t etc.)? ☐ Yes ☐ No	to take care of your baby (crib, car	Developmental			── □ Norm	nal elimination nal sleeping patterns_ e on back to sleep			
monthly (food,	monthly (food, housing, heat, etc.)? Yes No Who do you contact for help and/or support?			Developmental Surveillance (✓ Check those that apply) Social Language and Self–help □ Child can laugh out loud □ Child can look for you or another caregiver when upset Verbal Language (Expressive and Receptive) □ Child can tur						
Child care	· · · · · · · · · · · · · · · · · · ·	ng outside home? ☐ Yes ☐ No parents/caregivers ☐ Yes ☐ No	wrists when on stor	hild can support h mach □ Child ca ld can keep his/ho	nimself/herself on elbows an n roll over from stomach to er hands unfisted □ Child o	back *Anemi	eriodicity Schedule fo a Risk (Hemoglobin/ risk □ High risk			
How much stress are you and your family under <u>now</u> ? ☐ None ☐ Slight ☐ Moderate ☐ Severe What kind of stress? (✓ Check those that apply)			Concerns and/or qu							

Risk Indicators (✓ Check those that apply)

☐ Drugs (prescription or otherwise)_____

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance Other



Screen	Data		
oci ee ii	Date		

4 Month Form, Page 2

_ Age_____ Sex: □ M □ F

Physical Examir	nation (N=Normal, Abn=Abnormal)	Anticipatory Guidance	Plan of Care
General Appearance	- □ N □ Abn	(Consult Bright Futures, Fourth Edition for further information	Assessment ☐ Well Child ☐ Other Diagnosis
Skin	□ N □ Abn	https://brightfutures.aap.org)	
Neurological	□ N □ Abn		
Reflexes	□ N □ Abn	Social Determinants of Health	Immunizations
Head	□ N □ Abn	☐ Environmental risk (lead)	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Fontanelles	□ N □ Abn	☐ Family relationships and support	
Neck	□ N □ Abn	☐ Child care	Labs
Eyes	□ N □ Abn		☐ Hemoglobin/hematocrit (if high risk)
Red Reflex	□ N □ Abn	mant Bonavior and Bovolopmont	□ Other
Ocular Alignment	□ N □ Abn	ag	
Ears	□ N □ Abn	— 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1	
Nose	□ N □ Abn	,	
Oral Cavity/Throat	□ N □ Abn	— ☐ Media	Defermed a DiMeternel demonstrian 11 to 4100 and 405 7400
Lung	□ N □ Abn	— □ Playtime	Referrals ☐ Maternal depression - Help4WV.com/1-844-435-7498
Heart	□ N □ Abn	Out I Have like	☐ Developmental
Pulses	□ N □ Abn	Oral Health ☐ Maternal oral health	□ Other
Abdomen	□ N □ Abn	I Maternal oral health	D Dight from the Stort (DETS) 4 900 C42 0704
Genitalia	□ N □ Abn	☐ Teething and drooling	☐ Right from the Start (RFTS) 1-800-642-9704 ☐ Birth to Three (BTT) 1-800-642-9704
Back	□ N □ Abn	☐ Good oral hygiene (no bottle in bed)	☐ Children with Special HealthCare Needs (CSHCN)
Hips	□ N □ Abn	Nutrition and Feeding	
Extremities	□ N □ Abn	☐ General guidance on feeding	1-800-642-9704 ☐ Women, Infants and Children (WIC) 1-304-558-0030
LXUCITIUGS	LIN LADII	☐ Feeding choices (avoid grazing)	Wonten, infants and Children (WIC) 1-304-336-0030
Signs of Abuse	☐ Yes ☐ No	☐ Delaying solid foods	
Concerns and/or que	estions	□ Breastfeeding guidance	Prior Authorizations
·		☐ Supplements and over-the-counter medications	For treatment plans requiring authorization, please complete
		☐ Formula feeding guidance	page 3. Contact a HealthCheck Regional Program Specialist fo
		——————————————————————————————————————	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
		Safety Safety	
		— ☐ Car safety seats	Follow Up/Next Visit □ 6 months of age
		—— □ Safe sleep	Follow op/Next visit in 6 months of age
		☐ Safe home environment	□ Other
		□ Other	
			☐ Screen has been reviewed and is complete
		_	
			Please Print Name of Facility or Clinician
			Signature of Clinician/Title
			WEST VINCINAL

DOB_

Screen Date		Early and Periodic S		tment of Health and Human Res reatment (EPSDT) HealthCheck		entive Health Scree	6 Month Fori		
Name				DOB		Age	Sex: 🗆 M 🗆 F		
Weight	Length				_ Resp	Temp	Pulse Ox (optional)		
Allergies □ N	IKDA								
Current meds	□ None			· · · · · · · · · · · · · · · · · · ·					
☐ Foster child	d		🗆 (Child with special health care needs_					
Accompanied	d by □ Parent □ G	Grandparent □ Foster parent □ F	oster organization		□	Other			
•	n ☐ Periodic s s, surgeries, illnesse	creen s, visits to other providers and/or	*Positive screen = number *If positive, see Periodicity Postnatal Depression Scal Feelings over the past 2 w Little interest or pleasure in o	Schedule for link to Edinburgh e (EPDS) eeks: (✓ Check one for each question	Child ex ☐ Drugs ☐ Access Are the fi	(prescription or other s to firearm(s)/weapor	res E-Cigarettes Alcohol wise)		
□ Family health history reviewed Concerns and/or questions			□ Nearly every day(3) Feeling down, depressed, or hopeless □ Not at all □ Several days(1) □ More than ½ the days(2) □ Nearly every day(3) Concerns and/or questions			☐ Growth plotted on growth chart Do you think your child sees okay? ☐ Yes ☐ No Do you think your child hears okay? ☐ Yes ☐ No			
What is your fa		n?				alth uption □ Yes □ No oral health problems _			
Do you have the seat, diapers, o	Family relationships □ Good □ Okay □ Poor Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No		Developmental Developmental Surveillance (✓ Check those that apply) Social Language and Self-help □ Child can pat or smile at his/her			Water source ☐ Public ☐ Well ☐ Tested Fluoride supplementation ☐ Yes ☐ No Fluoride varnish applied (apply every 3 to 6 months) ☐ Yes ☐ No			
		ting basic family needs daily and/or ? □ Yes □ No	reflection ☐ Child can look when you call his/her name Verbal Language (Expressive and Receptive) ☐ Child can babble		Nutrition □ Breast	Nutrition/Sleep ☐ Breastfeeding - Frequency			
Who do you co	ontact for help and/o	or support?		oll over from back to stomach ☐ Ch	☐ Bottle	feeding - Amount	Frequency		
Child careChild has abilit	ity to separate from p	ng outside home? ☐ Yes ☐ No parents/caregivers ☐ Yes ☐ No ur family under <u>now</u> ?	can sit briefly without support Fine Motor □ Child can pass a toy from one hand to another □ Child can rake small objects with 4 fingers □ Child can bang small objects on surface Concerns and/or questions_		small ☐ Has st☐ Vitami☐ Norma	☐ Juice ☐ Water ☐ Has started solid foods ☐ Normal eating habits ☐ Vitamins ☐ Normal elimination			
□ None □ SI	light ☐ Moderate	□ Severe			— □ Place	on back to sleeps and/or guestions			

☐ Relationships (partner, family and/or friends) ☐ School/work
☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance Other



6 Month Form, Page 2

Sex: □ M □ F

Age_

*See Periodicity Sc	hedule for Risk Factors	Anticipatory Guidance	Plan of Care
*Lead Risk □ Low risk □ High	risk	(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)	Assessment □ Well Child □ Other Diagnosis
*Tuberculosis Risk □ Low risk □ High		Social Determinants of Health ☐ Living situation and food security	Immunizations □ UTD □ Given, see immunization record □ Entered into WVSIIS
Physical Examir	nation (N=Normal, Abn=Abnormal)	☐ Tobacco, alcohol, and drugs ☐ Parental depression	Labs
General Appearance	□ N □ Abn	☐ Family relationships and support	☐ Blood lead (if high risk) (enter into WVSIIS)
Skin	□N □ Abn	☐ Child care	☐ TB skin test (if high risk)
Neurological	□ N □ Abn		□ Other
Reflexes	□ N □ Abn	Infant Behavior and Development	
Head	□ N □ Abn	☐ Parents as teachers	
Fontanelles	□ N □ Abn	☐ Community and early literacy	
Neck	□ N □ Abn	☐ Media	
Eyes	□ N □ Abn	☐ Emerging infant independence	Referrals ☐ Maternal depression - Help4WV.com/1-844-435-7498
Red Reflex	□ N □ Abn	☐ Putting self to sleep	□ Developmental
Ocular Alignment	□ N □ Abn	☐ Self-calming	□ Other
Ears	□ N □ Abn		
Nose	□ N □ Abn	Oral Health	☐ Right from the Start (RFTS) 1-800-642-9704
Oral Cavity/Throat	□ N □ Abn	☐ Fluoride, oral hygiene/soft toothbrush, avoidance of bottle in bed	☐ Birth to Three (BTT) 1-800-642-9704
Lung	□ N □ Abn	N / '''	☐ Children with Special HealthCare Needs (CSHCN)
Heart	□ N □ Abn	···a··································	1-800-642-9704
Pulses	□ N □ Abn	_ contra garantee on recarring	☐ Women, Infants and Children (WIC) 1-304-558-0030
Abdomen	□ N □ Abn	□ Solid foods	
Genitalia	□ N □ Abn	_ · · · · · · · · · · · · · · · · · · ·	
Back	□ N □ Abn	_ : :::::::::::::::::::::::::::::::::::	Prior Authorizations
Hips	□ N □ Abn		For treatment plans requiring authorization, please complete
Extremities	□ N □ Abn	──── □ Formula-feeding guidance	page 3. Contact a HealthCheck Regional Program Specialist fo assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
Signs of Abuse	□ Yes □ No	Safety	accionance at 1 coc 0.2 o. o. o. annimorigo micaninono.
•	estions	☐ Car safety seats	
Corrocinio ana/or que	50015	□ Safe sleep	Follow Up/Next Visit □ 9 months of age
		☐ Safe home environment (burns, sun exposure, choking, poisoning, drowning, falls)	□ Other
		□ Other	☐ Screen has been reviewed and is complete
			Please Print Name of Facility or Clinician
			Signature of Clinician/Title

DOB_

Screen Date_		West Virginia Department of Health and Human Resources Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Hea							
Name			3 ,		DOB		Age_		
Weight	Length	Weight for Length	HC	Pulse	BP (optional)	Resp	Temp		

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3	IVIC	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	гυ	

Name		DOB		Age	Sex: 🗆 M 🗆 F
Weight Length Weight for Length	HC Pulse	BP (optional)	RespTemp		Pulse Ox (optional)
Allergies 🗆 NKDA					
Current meds None					
□ Foster child	□ Chi	ld with special health care needs_			
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ F	Foster organization		□ Other		
Medical History	Developmental		☐ Place on back to s	sleep	
☐ Initial screen ☐ Periodic screen	Standardized Screening Tool	e and screening completed with	Concerns and/or que	stions	
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	□ ASQ3 □ Other tool Results in child's record □ \ Concerns and/or questions				
□ Family health history reviewed			*See Periodicity Sci *Lead Risk Low risk High		Factors
Concerns and/or questions	Risk Indicators (✓ Check t	hose that apply)	Physical Examin		nal, Abn=Abnormal)
Social/Psychosocial History What is your family's living situation?	Child exposed to ☐ Cigarette ☐ Drugs (prescription or otherw ☐ Access to firearm(s)/weapon	vise) v(s)	Skin Neurological	□ N □ Abn □ N □ Abn	
Family relationships □ Good □ Okay □ Poor Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No	Are the firearm(s)/weapon(s) so General Health ☐ Growth plotted on growth ch		Reflexes Head Fontanelles Neck	□ N □ Abn □ N □ Abn	
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No	Do you think your child sees ok Do you think your child hears o	ay? □ Yes □ No	Eyes Red Reflex Ocular Alignment	□ N □ Abn □ N □ Abn	
Who do you contact for help and/or support?	Oral Health Tooth eruption ☐ Yes ☐ No		Ears Nose	□ N □ Abn	
Are you and/or your partner working outside home? ☐ Yes ☐ No Child care	Current oral health problems _ Water source ☐ Public ☐ We Fluoride supplementation ☐ Ye		Oral Cavity/Throat Lung Heart	□ N □ Abn	
Child has ability to separate from parents/caregivers ☐ Yes ☐ No	Fluoride varnish applied (apply	every 3 to 6 months)	Pulses Abdomen	□ N □ Abn	
How much stress are you and your family under <u>now</u> ? □ None □ Slight □ Moderate □ Severe What kind of stress ? (✓ Check those that apply) □ Relationships (partner, family and/or friends) □ School/work	Nutrition/Sleep ☐ Breastfeeding - Frequency _ ☐ Bottle feeding - Amount		Genitalia Back Hips Extremities	□ N □ Abn □ N □ Abn □ N □ Abn	
□ Child care □ Drugs □ Alcohol □ Violence/abuse (physical, emotional and/or sexual) □ Family member incarcerated □ Lack of support/help □ Financial/money □ Emotional loss □ Health insurance □ Other	☐ Formula ☐ Juice ☐ Water ☐ Has started solid foods ☐ ☐ ☐ Vitamins ☐ Normal elimination	Fable foods □ Normal eating hab	Signs of Abuse Concerns and/or que	☐ Yes ☐ No	
	☐ Normal sleeping patterns		Continue on pag	je 2	

creen Date		9 Month Form, Page
Name	DOB	Age Sex: □ M □ F
Anticipatory Guidance	Questions/Concerns/Notes	Plan of Care
(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)		Assessment
Social Determinants of Health		Immunizations
☐ Intimate partner violence		□ UTD □ Given, see immunization record □ Entered into WVSIIS
☐ Family relationships and support		Laha
Infant Behavior and Development		Labs ☐ Blood lead (if high risk) (enter into WVSIIS)
☐ Changing sleep pattern (sleep schedule)		☐ Other
☐ Developmental mobility and cognitive development		
☐ Interactive learning and communication		
☐ Media		
Discipline		Referrals
☐ Parent expectations of child's behavior		□ Developmental
Nutrition and Feeding		□ Other
☐ Self-feeding, mealtime routines, transition to solid foods (table		☐ Right from the Start (RFTS) 1-800-642-9704
food introduction), cup drinking		☐ Birth to Three (BTT) 1-800-642-9704
☐ Plans for weaning		☐ Children with Special HealthCare Needs (CSHCN)
Safety		1-800-642-9704 ☐ Women, Infants and Children (WIC) 1-304-558-0030
☐ Car safety seats		
☐ Heatstroke prevention		Prior Authorizations
☐ Firearm safety ☐ Safe home environment (burns, poisoning, drowning, falls)		For treatment plans requiring authorization, please complete
ale nome environment (burns, poisoning, drowning, rails)		page 3. Contact a HealthCheck Regional Program Specialist for
☐ Other		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
		Follow Up/Next Visit 12 months of age
		□ Other
		☐ Screen has been reviewed and is complete
	 	
	+	
	Ī	Discoo Daint Name of Facility or Olivinia
		Please Print Name of Facility or Clinician

Signature of Clinician/Title

Screen Date	Early and Periodic			ent of Health and Human tment (EPSDT) HealthCh		ventive Health Scre	en	12 Month Form	
Name				DOB		Ag	e	Sex: 🗆 M 🗆 F	
Weight Length_	Weight for Length	HC	Pulse	BP (optional)	Resp	Temp	Pulse Ox ((optional)	
Allergies □ NKDA									
Current meds ☐ None	 		· · · · · · · · · · · · · · · · · · ·						
☐ Foster child				d with special health care ne	eds				
Accompanied by ☐ Parent	☐ Grandparent ☐ Foster parent	□ Foster organiz	ration		c	Other			
Recent injuries, surgeries, illr	odic screen nesses, visits to other providers and/or	Social Lan (point to rec Child car Verbal Lan	ental Surveillance (guage and Self-hel quest an object)	Check those that apply) p □ *Child can protoimpera Child can imitate new gesture cts and Receptive) □ *Child can and sounds □ Child can	tive point Tooth e Curren Water s	ealth referral required at 12 eruption	Vell □ Tested Yes □ No		
☐ Family health history rev	"Dada" or "I	"Dada" or "Mama" specifically ☐ Child can use 1 word other than "Mama," "Dada," or personal name Gross Motor ☐ Child can take first independent steps ☐ Child can			□ No				
Concerns and/or questions_	Gross Mot				on/Sleep stfeeding - Frequency	·			
Family relationships Good Do you have the things you n	tuation?	small object eat it *Absence of Concerns a	c	n object in a cup □ Child ca r grasp □ Child can pick up = Autism Screen	n pick up of food and of food	☐ Bottle feeding - Amount Frequency			
monthly (food, housing, heat,	meeting basic family needs daily and, etc.)? Yes No and/or support?	— Child expo — □ Drugs (p		s □ E-Cigarettes □ Alcoho se)		eriodicity Schedule t	for Risk Factors		
Child care	working outside home? ☐ Yes ☐ No	— Are the fire	arm(s)/weapon(s) se	cured? □ Yes □ No □ NA	*Anem Hemog	ia Risk (Hemoglobin globin/hematocrit req	/Hematocrit) puired at 12 monti	hs	
How much stress are you an ☐ None ☐ Slight ☐ Moder What kind of stress? (✓ Che	rate □ Severe		Health Dolotted on growth cha k your child sees oka		*Tuber	culosis Risk risk □ High risk			

Do you think your child hears okay? ☐ Yes ☐ No

☐ Relationships (partner, family and/or friends) ☐ School/work

☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance ☐ Other_



Screen	Date		

12 Month Form, Page 2

Sex: □ M □ F

Name		DOB	Age Sex: 🗆 M 🗆
Physical Examir	nation (N=Normal, Abn=Abnormal)	Anticipatory Guidance	Plan of Care
General Appearance	e □ N □ Abn	(Consult Bright Futures, Fourth Edition for further information	Assessment ☐ Well Child ☐ Other Diagnosis
Skin	□ N □ Abn	https://brightfutures.aap.org)	
Neurological	□ N □ Abn		Immunizations
Reflexes	□ N □ Abn	Social Determinants of Health	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Head	□ N □ Abn	☐ Living situation and food security	
Fontanelles	□ N □ Abn	☐ Tobacco, alcohol, and drugs	Labs
Neck	□ N □ Abn	☐ Social connections with family, friends, child care, home visitation	☐ Hemoglobin/hematocrit (required at 12 months)
Eyes	□ N □ Abn	program staff, and others	☐ Blood lead (required at 12 months) (enter into WVSIIS)
Red Reflex	□ N □ Abn		☐ TB skin test (if high risk)
Ocular Alignment	□ N □ Abn	Establishing Routines	□ Other
Ears	□ N □ Abn	— · · · · · · · · · · · · · · · · · · ·	
Nose	□ N □ Abn	,	
Oral Cavity/Throat	□ N □ Abn	□ Bedtime, naptime, and teeth brushing	
Lung	□ N □ Abn	—— ☐ Media	B ()
Heart	□ N □ Abn	Fooding and Appetite Observes	Referrals
Pulses	□ N □ Abn		☐ Developmental ☐ Dental ☐ Blood lead ≥5ug/dl
Abdomen	□ N □ Abn		□ Other
Genitalia	□ N □ Abn	☐ Continued breastfeeding and transition to family meals	
Back	□ N □ Abn	□ Nutritious foods	D Dieth to Three (DTT) 4 900 C42 9704
Hips	□ N □ Abn	Establishing a Dental Home	☐ Birth to Three (BTT) 1-800-642-9704
Extremities	□ N □ Abn		☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704
LAUGITHUES	LIN LIABIII	D First dental checkup and dental hygiene	□ Women, Infants and Children (WIC) 1-304-558-0030
Signs of Abuse	☐ Yes ☐ No	Safety	Women, infants and Children (WIC) 1-304-336-0030
Concerns and/or que	estions	☐ Car safety seats	
·		— ☐ Gall safety scales	Prior Authorizations
		□ Drowning prevention and water safety	For treatment plans requiring authorization, please complete
		□ Sun protection	page 3. Contact a HealthCheck Regional Program Specialist fo
		— Pets	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
		□ Safe home environment: poisoning	
		— Deale notice environments possenting	
		— □ Other	Follow Up/Next Visit ☐ 15 months of age
			□ Other
			- Other
			☐ Screen has been reviewed and is complete
			Places Brint Name of Facility or Clinician
			Please Print Name of Facility or Clinician
			Signature of Clinician/Title
			Signature of Chilliolan Filic

Screen Date		Early and Periodi			ent of Health and Human atment (EPSDT) HealthCh		n Preventive Health	Screen		15 Month Form
Name					DOB			Age		_ Sex: □ M □ F
Weight Le	ngth V	Veight for Length	HC	Pulse	BP (optional)	Resp_	Temp		Pulse Ox (op	tional)
Allergies ☐ NKDA					· · · · · · · · · · · · · · · · · · ·					
Current meds ☐ None	.									
☐ Foster child		· · · · · · · · · · · · · · · · · · ·		Chil	d with special health care ne	eeds				
Accompanied by □ P	arent 🛮 Grandpar	ent □ Foster parent	☐ Foster organiz	zation			Dother			· · · · · · · · · · · · · · · · · · ·
Recent injuries, surgeri		to other providers and/o	Social Lan r (point to co between ob something	ental Surveillance (guage and Self-hel mment on an interes oject/event and parer to get help Child	✓ Check those that apply) Ip □ *Child can prodeclaratiting object/event-will look alto th) □ Child can point to ask the can look around when you sate of the can look around when you sate of the can look around when you sate of the can look around when your blanket?" □ Child	ive point () ternatively () for () ay things ()	Oral Health Date of last dental visit Current oral health pro Water source □ Publi Fluoride supplementati Fluoride varnish applie □ Yes □ No □	blems ic □ Well □ ion □ Yes □ d <i>(apply ever</i>	Tested I No y 3 to 6 month	s)
			imitate scrib	like "Where's your ball?" or "Where's your blanket?" ☐ Child can imitate scribbling ☐ Child can drink from a cup with little spilling Verbal Language (Expressive and Receptive) ☐ Child can use words other than names ☐ Child can speak in sounds like an			Nutrition/Sleep □ Breastfeeding - Fred	quency		
What is your family's liv	Social/Psychosocial History What is your family's living situation? Family relationships Good Okay Poor			unknown language ☐ Child can follow directions that do not include a gesture Gross Motor ☐ Child can squat to pick up objects ☐ Child can crawl up a few steps ☐ Child can run Fine Motor ☐ Child can make marks with a crayon ☐ Child can drop an object in and take object out of a container			□ Formula Plans for weaning □ Milk □ Juice □ Water			
		are of your baby (crib, c	7	of these milestones and/or questions	s = Autism Screen		□ Normal sleeping pat Concerns and/or quest	terns		
		c family needs daily and s □ No				-				
Who do you contact for	help and/or suppor	t?	— Child expo		es □ E-Cigarettes □ Alcoho	ol ,	See Periodicity Sche	edule for Ris	k Factors	
Child care	-	le home? □ Yes □ No caregivers □ Yes □ No	☐ Access t — Are the fire	o firearm(s)/weapon arm(s)/weapon(s) se	se)s) s) cured? □ Yes □ No □ NA		*Anemia Risk (Hemoglobin/Hematocrit) □ Low risk □ High risk			
How much stress are y □ None □ Slight □ I What kind of stress? (□ Relationships (partne	Moderate □ Sever	re t apply)	General	Health	art		- LOW HOK - LINGHTH			

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical,

support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance ☐ Other_

emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of



_	_		
Screen	Date		

Name		DOB	Age Sex: 🗆 M 🗆 F
Physical Examin	nation (N=Normal, Abn=Abnormal)	Anticipatory Guidance	Plan of Care
General Appearance	e □N □ Abn	(Consult Bright Futures, Fourth Edition for further information	Assessment ☐ Well Child ☐ Other Diagnosis
Skin	□ N □ Abn	https://brightfutures.aap.org)	
Neurological	□ N □ Abn		Immunizations
Reflexes	□ N □ Abn	Communication and Social Development	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Head	□ N □ Abn	☐ Individuation	
Neck	□ N □ Abn	☐ Separation	Labs
Eyes	□ N □ Abn	☐ Finding support	☐ Hemoglobin/hematocrit (if high risk)
Red Reflex	□ N □ Abn	☐ Attention to how child communicates wants and interests	☐ Blood lead (if high risk) (enter into WVSIIS)
Ocular Alignment	□ N □ Abn	Sleep Routines and Issues	□ Other
Ears	□ N □ Abn	☐ Regular bedtime routine, night waking, no bottle in bed	
Nose	□ N □ Abn	Thegular beduine routine, hight waking, no bottle in bed	
Oral Cavity/Throat	□ N □ Abn	Temperament, Development, Behavior, and Discipline	Referrals
Lung	□ N □ Abn		☐ Developmental ☐ Dental
Heart	□ N □ Abn	□ Discipline and behavior management	□ Other
Pulses	□ N □ Abn		2 6 11 61
Abdomen	□ N □ Abn	Healthy Teeth	
Genitalia	□ N □ Abn	□ Brushing teeth	☐ Birth to Three (BTT) 1-800-642-9704
Back	□ N □ Abn	☐ Reducing caries	☐ Children with Special HealthCare Needs (CSHCN)
Hips	□ N □ Abn		1-800-642-9704
Extremities	□ N □ Abn	Safety	☐ Women, Infants and Children (WIC) 1-304-558-0030
		☐ Car safety seats and parental use of seat belts	
Signs of Abuse	☐ Yes ☐ No	☐ Safe home environment: poisoning, falls, and fire safety	
Concerns and/or que	estions		Prior Authorizations
		□ Other	For treatment plans requiring authorization, please complete
			page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
			assistance at 1-600-642-9704 or unin.wv.gov/neatmeneck
			Follow Up/Next Visit □ 18 months of age
			Other
			☐ Screen has been reviewed and is complete
			·
			-
			Please Print Name of Facility or Clinician
			_
			Signature of Clinician/Title

Screen Date	Early and Periodic			ent of Health and Human R tment (EPSDT) HealthChed		entive Health Scre	en	18 Month Form
Name				DOB		Ag	je	Sex: 🗆 M 🗆 F
Weight Length	Weight for Length	HC	Pulse	BP (optional)	Resp	Temp	Pulse Ox	(optional)
Allergies □ NKDA								
Current meds ☐ None								
☐ Foster child			□ Chil	d with special health care need	ls			
Accompanied by ☐ Paren	nt □ Grandparent □ Foster parent [⊐ Foster organiza	ation		□	Other		
Recent injuries, surgeries, il	riodic screen Ilnesses, visits to other providers and/or	Standardize ASQ3 Results in ch	nental surveillance ed Screening Tool ☐ Other tool — Y	es □ No	Current of Water so Fluoride	ast dental visit_ oral health problems urce □ Public □ V supplementation □	Vell □ Tested Yes □ No	
☐ Family health history re	eviewed	Concerns ar	nd/or questions		☐ Yes □	varnish applied <i>(app</i>] No		
Concerns and/or questions_			creening complete	d with an Autism Specific To	□ Bottle	feeding - Frequency feeding - Amount	F	requency
Social/Psychosocial I What is your family's living s	History situation?		nild's record	es 🗆 No	Plans for □ Milk □	la weaning Juice □ Water al eating habits		
	od □ Okay □ Poor I need to take care of your baby (crib, ca Is □ No	r Child expos	escription or otherw	s □ E-Cigarettes □ Alcohol ise)	☐ Norma ☐ Norma Hours of	al elimination al sleeping patterns_		
monthly (food, housing, hea	you have concerns about meeting basic family needs daily and/or nthly (food, housing, heat, etc.)? ☐ Yes ☐ No		□ Access to firearm(s)/weapon(s) Are the firearm(s)/weapon(s) secured? □ Yes □ No □ NA □ Witnessed violence/abuse □ Threatened with violence/abu					
Who do you contact for help	p and/or support?	— Grary exp	erience that your ch	ilid cannot lorget	*Soo Por	riodicity Schedule t	for Dick Eactors	
Child care	r working outside home? ☐ Yes ☐ No	Concerns ar	nd/or questions		*Anemia	Risk (Hemoglobin sk 🛘 High risk		
How much stress are you a □ None □ Slight □ Mode What kind of stress? (✓ C.	and your family under <u>now</u> ? erate □ Severe	Do you think	otted on growth cha	art ay? □ Yes □ No ay? □ Yes □ No	*Lead Ri □ Low ris	sk sk □ High risk		

☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance ☐ Other_



Screen	Data		
JUICELL	Date		

18 Month Form, Page 2

_ Age_____ Sex: 🗆 M 🗆 F

Physical Exami	nation (N=No	ormal, Abn=Abnormal)	Anticipatory Guidance	Plan of Care
•	•	n	(Consult Bright Futures, Fourth Edition for further information	Assessment □ Well Child □ Other Diagnosis
Skin		n	https://brightfutures.aap.org)	
Neurological		n		Immunizations
Reflexes		n	Temperament, Development, Toilet Training, Behavior and	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Head		n	Discipline	
Neck		n	☐ Anticipation of return to separation anxiety and managing	Labs
Eyes		n	behavior with consistent limits	☐ Hemoglobin/hematocrit (if high risk)
Red Reflex		n	☐ Recognizing signs of toilet training and readiness and parental	☐ Blood lead (if high risk) (enter into WVSIIS)
Ocular Alignment		n	expectations	□ Other
Ears	ПИПАЬ	n	☐ New sibling planned or on the way	
Nose		n		
Oral Cavity/Throat		n	Communication and Social Development	
Lung		n	☐ Encouragement of language, use of simple words and phrases,	Referrals
Heart	ПИПАЬ	n	encouragement in reading, playing, talking, and singing	☐ Developmental ☐ Dental
Pulses		n	Television Viewing and Digital Media	□ Other
Abdomen		n	☐ Promotion of reading, physical activity and safe play	
Genitalia		n	1 Tomotion of reading, physical activity and sale play	☐ Birth to Three (BTT) 1-800-642-9704
Back		n	Healthy Nutrition	☐ Children with Special HealthCare Needs (CSHCN)
Hips		n	□ Nutritious foods	1-800-642-9704
Extremities		n	□ Water, milk, juice	☐ Women, Infants and Children (WIC) 1-304-558-0030
			☐ Expressing independence through food likes and dislikes	
Signs of Abuse	☐ Yes ☐ N	lo		
Concerns and/or qu	estions		Safety	Prior Authorizations
			☐ Car safety seats and parental use of seat belts	For treatment plans requiring authorization, please complete
			☐ Sun protection	page 3. Contact a HealthCheck Regional Program Specialist for
			☐ Firearm safety	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
			☐ Safe home environment: burns, fires, and falls	
			□ Other	Follow Up/Next Visit ☐ 24 months of age
			- Other	C Other
				□ Other
				☐ Screen has been reviewed and is complete
				Please Print Name of Facility or Clinician
				Signature of Clinician/Title
		 		

DOB_

Screen Date Early and I	Periodic Screen	West Virginia Depa ing, Diagnosis, and T	rtment of Health and Huma reatment (EPSDT) HealthC	n Resource heck Prog	es ram Preventive Health Scree	2 n	4 Month Form	
Name			DOB		Age	Se	ex: 🗆 M 🗆 F	
Weight Height BMI	HC	Pulse	BP (optional)	Resp_	Temp	Pulse Ox (optional)		
Allergies NKDA								
Current meds ☐ None								
□ Foster child								
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster p	parent □ Foster	organization			□ Other			
Medical History	De	velopmental			General Health			
☐ Initial screen ☐ Periodic screen			ce (✓ Check those that apply)		☐ Growth plotted on growth cl	nart		
Recent injuries, surgeries, illnesses, visits to other provide			other children, also called para lothing □ Child can scoop we		Do you think your child sees o	,		
counselors and/or hospitalizations:			words ☐ Child can combine 2		Do you think your child hears okay? ☐ Yes ☐ No			
	sho	•	Child can follow 2-step comm		Oral Health			
T Comilly bookle bistomy was issued			body parts, such as nose and					
☐ Family health history reviewed			derstandable to strangers □ (o off the ground with 2 feet □		Current oral health problems Water source			
Concerns and/or questions_		•	ld can climb up a ladder at a p		Fluoride supplementation			
		Child can stack objects [☐ Child can turn book pages □	Child can	Fluoride varnish applied (appl	•		
			jects like knobs, toys, and lids	☐ Child	□ Yes □ No		· · · · · · · · · · · · · · · · · · ·	
Social/Psychosocial History		draw a line			Nutrition/Sleep			
What is your family's living situation?	Col	icerris arid/or questioris_			_ Nutrition/sieep □ Normal eating habits			
					Fruits/vegetables/lean protein per day			
Family relationships ☐ Good ☐ Okay ☐ Poor	4-11				□ Vitamins			
Do you have concerns about meeting basic family needs d monthly (food, housing, heat, etc.)? ☐ Yes ☐ No		Autism screening comp 4-CHAT-R/F □ Other to	leted with an Autism Specifi	c Tool	☐ Normal elimination Toilet trained ☐ Yes ☐ No			
Who do you contact for help and/or support?		ults in child's record			☐ Normal sleeping patterns			
		cerns and/or questions_			Hours of sleep each night?			
					Concerns and/or questions			
Are you and/or your partner working outside home? ☐ Ye Child care	S LI NO							
Child has ability to separate from parents/caregivers ☐ Ye	s □ No	dr. Indicatora (/ Ob-	-1.414141.3					
	KIS	sk Indicators (✓ Che	ck tnose tnat apply) rettes □ E-Cigarettes □ Alcol	nol	*0 Dili-i+- O-ll-I- f-	Diete Eesteur		
How much stress are you and your family under <u>now</u> ?			erwise)	101	*See Periodicity Schedule fo	or RISK Factors		
□ None □ Slight □ Moderate □ Severe		ccess to firearm(s)/weap	oon(s)		*Anemia Risk (Hemoglobin/I	Hematocrit)		
What kind of stress? (✓ Check those that apply)		, , , ,) secured? ☐ Yes ☐ No ☐ N		□ Low risk □ High risk			
☐ Relationships (partner, family and/or friends) ☐ School			e		*Lead Risk Blood lead required at 24 mg	ontho		

Do you utilize a car seat for your child? ☐ Yes ☐ No

Concerns and/or questions___

☐ Excessive television/video game/internet/cell phone use

emotional and/or sexual) $\ \square$ Family member incarcerated $\ \square$ Lack of

support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance ☐ Other_

*Tuberculosis Risk

☐ Low risk ☐ High risk

***Dyslipidemia Risk**□ Low risk □ High risk



Screen	Date		

24 Month Form, Page 2

Sex: □ M □ F

Name		DOB	Age Sex: 🗆 M 🖂
Physical Examin	nation (N=Normal, Abn=Abnormal)	Anticipatory Guidance	Plan of Care
-	e □N □ Abn	(Consult Bright Futures, Fourth Edition for further information	Assessment □ Well Child □ Other Diagnosis
Skin	□ N □ Abn	https://brightfutures.aap.org)	-
Neurological	□ N □ Abn		Immunizations
Reflexes	□ N □ Abn	Social Determinants of Health	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Head	□ N □ Abn	☐ Intimate partner violence	
Neck	□ N □ Abn	☐ Living situation and food security	Labs
Eyes	□ N □ Abn	☐ Tobacco, alcohol, and drugs	☐ Hemoglobin/hematocrit (if high risk)
Red Reflex	□ N □ Abn	☐ Parental well-being	☐ Blood lead (required at 24 months) (enter into WVSIIS)
Ocular Alignment	□ N □ Abn		☐ TB skin test (if high risk)
Ears	□ N □ Abn	Temperament and Behavior	☐ Lipid profile (if high risk)
Nose	□ N □ Abn	—	□ Other
Oral Cavity/Throat	□ N □ Abn	— · -····	
Lung	□ N □ Abn	☐ Promotion of physical activity and safe play	Defermely
Heart	□ N □ Abn	☐ Limits on media use	Referrals
Pulses	□ N □ Abn	Assessment of Language Development	☐ Developmental ☐ Dental ☐ Blood lead ≥5ug/dl
Abdomen	□ N □ Abn		☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
Genitalia	□ N □ Abn		□ Other
Back	□ N □ Abn	I romotion of reading	
Hips	□ N □ Abn	Toilet Training	☐ Birth to Three (BTT) 1-800-642-9704
Extremities	□ N □ Abn	□ Techniques	☐ Children with Special HealthCare Needs (CSHCN)
		☐ Personal hygiene	1-800-642-9704
Signs of Abuse	☐ Yes ☐ No		☐ Women, Infants and Children (WIC) 1-304-558-0030
Concerns and/or que	estions	Safety	
		— □ Car safety seats	D. A. (1)
		☐ Outdoor safety	Prior Authorizations
		— □ Firearm safety	For treatment plans requiring authorization, please complet
			page 3. Contact a HealthCheck Regional Program Specialist fo
		— □ Other	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
			_
			Follow Up/Next Visit
			□ Other
			☐ Screen has been reviewed and is complete
		<u> </u>	_
			_
			Please Print Name of Facility or Clinician
			Signature of Clinician/Title

Screen Date	Early and Po	West Virgin eriodic Screening, Diagnosi		ith and Human Resou SDT) HealthCheck Pr		Ith Screen	30 Month Form	
Name		····		DOB		Age	Sex: □M □F	
Weight H	eight BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional)_	· · · · · · · · · · · · · · · · · · ·	
Allergies □ NKDA								
Current meds ☐ None								
☐ Foster child			□ Child with spec	ial health care needs				
Accompanied by ☐ Parer	nt □ Grandparent □ Foster pa	arent □ Foster organization						
Medical History		Developmental						
Recent injuries, surgeries, counselors and/or hospitali	riodic screen Ilnesses, visits to other providers zations:	□ Developmental Standardized Scre and/or □ ASQ3 □ Oth Results in child's re	□ Developmental surveillance and screening completed with Standardized Screening Tool □ ASQ3 □ Other tool □ Results in child's record □ Yes □ No Concerns and/or questions			Oral Health Date of last dental visit Current oral health problems Water source □ Public □ Well □ Tested Fluoride supplementation □ Yes □ No Fluoride varnish applied (apply every 3 to 6 months)		
☐ Family health history re	eviewed				Lifes Lino			
Family relationships ☐ Go Do you have concerns abo	History situation? od □ Okay □ Poor ut meeting basic family needs da	Child exposed to □ Drugs (prescripti □ Access to firearr Are the firearm(s)/v □ Witnessed violer □ Scary experience	veapon(s) secured?	rettes □ Alcohol Yes □ No □ NA tened with violence/abus	□ Vitamins □ Normal eliminatio Toilet trained □ Ye □ Normal sleeping Hours of sleep each	an protein per dayn		
	at, etc.)? □ Yes □ No o and/or support?	Do you utilize a car seat for your child? ☐ Yes ☐ No ☐ Excessive television/video game/internet/cell phone use Concerns and/or questions_						
Child care	r working outside home? ☐ Yes					chedule for Risk Factors noglobin/Hematocrit) n risk		
□ None □ Slight □ Mod What kind of stress? (✓ O □ Relationships (partner, fa □ Child care □ Drugs □ A emotional and/or sexual) □		Do you think your of ical,			*Lead Risk □ Low risk □ Higl *Tuberculosis Risk □ Low risk □ Higl	Ĭ.		

insurance ☐ Other_



Screen	Date		

30 Month Form, Page 2

Age__

Sex: □ M □ F

Physical Examin	action (N-Normal Abn-Abnarmal)	Anticinatory Guidance	Plan of Care
•	nation (N=Normal, Abn=Abnormal)	Anticipatory Guidance	
	e □ N □ Abn	(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)	Assessment □ Well Child □ Other Diagnosis
Skin	□ N □ Abn	Thtps://brightrutures.aap.org/	Immunizations
Neurological	□ N □ Abn	Social Determinants of Health	☐ UTD ☐ Given, see immunization record ☐ Entered into WVSIIS
Reflexes	□ N □ Abn	☐ Intimate partner violence	Given, see inimunization record in Entered into WV3113
Head	□ N □ Abn	☐ Living situation and food security	Labs
Neck	□ N □ Abn	☐ Tobacco, alcohol, and drugs	☐ Hemoglobin/hematocrit (if high risk)
Eyes	□ N □ Abn	☐ Parental well-being	☐ Blood lead (if not completed at 12 and/or 24 months or high risk)
Red Reflex	□ N □ Abn	— Parental well-being	(enter into WVSIIS)
Ocular Alignment	□ N □ Abn	Temperament and Behavior	☐ TB skin test (if high risk)
Ears	□ N □ Abn	— □ Development	, ,
Nose	□ N □ Abn	□ Temperament	□ Other
Oral Cavity/Throat	□ N □ Abn	□ Promotion of physical activity and safe play	
Lung	□ N □ Abn	D Promotion of physical activity and safe play D Limits on media use	Referrals
Heart	□ N □ Abn	Limits on media use	☐ Developmental ☐ Dental
Pulses	□ N □ Abn	Assessment of Language Development	☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
Abdomen	□ N □ Abn	☐ How child communicates and expectations for language	·
Genitalia	□ N □ Abn		□ Other
Back	□ N □ Abn	D Fromotion of reading	
Hips	□ N □ Abn	Toilet Training	☐ Children with Special HealthCare Needs (CSHCN)
Extremities	□ N □ Abn	☐ Techniques	1-800-642-9704
Extremities		☐ Personal hygiene	☐ Women, Infants and Children (WIC) 1-304-558-0030
Signs of Abuse	☐ Yes ☐ No	Li r el soliai flyglerie	☐ Birth to Three (BTT) transition planning
Concerns and/or que	estions	Safety	Diffice (DTT) transition planning
·		☐ Car safety seats	
		U Outdoor safety	
		☐ Firearm safety	Prior Authorizations
		Li i ileaith salety	For treatment plans requiring authorization, please complete
		□ Other	page 3. Contact a HealthCheck Regional Program Specialist fo assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
			Follow Up/Next Visit
			Other
			☐ Screen has been reviewed and is complete
			Please Print Name of Facility or Clinician
			Signature of Clinician/Title

DOB_

Screen Date		Early and Periodic	West Virginia Department of Health and Human Resources Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen					
Name					DOB		Age	Sex: 🗆 M 🗆 F
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (option	nal)
Allergies □ NKD	DA							
Current meds □	I None							
						IEP/section 504 in plac	ce	
Accompanied by	□ Parent □ Grandpar	rent □ Foster parent □	Foster organization	· · · · · · · · · · · · · · · · · · ·				
Water source Fluoride supplem Fluoride varnish a Fluoride varnish a Ves No Vision Acuity So R Wears glasses? Hearing Screen Do you think your	th problems	ed o 6 months) TO (retest in 6 months) ired)	□ Child can enter be can put on coat, jac independently □ C play in cooperation □ Child can speak □ Child can tell you things using words simple prepositions □ Child can climb of forward □ Child ca with head and 1 oth	parteillance (Check the pathroom and urinate be cket or shirt by themsel child can engage in image and share Child can engage in words that are 75% as a story from a book of like bigger or shorter law, such as on or under on and off couch or chand draw a single circle ner body part Child	y himself/herself	□ UTD □ Given, se Referrals: □ Develo □ Mental/behavioral □ Dental □ Vision □ Other □ Children with Spectors 1-800-642-9704 □ Women, Infants and	health/trauma - Help4WV.c Hearing Hearing HealthCare Needs (CS CS CHART CONTROL CHART CONT	Entered into WVSIIS com/1-844-435-7498 HCN)
		The informa	tion above this line	 is intended to be rel	eased to meet school ent			
□ Initial Screen □ Periodic Screen Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations: □ Family health history reviewed □ Concerns and/or questions □ Periodic Screen □ How much stre □ None □ Slig What kind of s □ Relationships □ Child care □ emotional and/or support/help □			How much stress a None Slight What kind of stres Relationships (pa Child care Driemotional and/or sessupport/help Fin	are you and your family □ Moderate □ Seve ss? (✓ Check those tha artner, family and/or fri ugs □ Alcohol □ Viol	ere at apply) ends) □ School/work ence/abuse (physical, per incarcerated □ Lack of tional loss	Child exposed to □ Cigarettes □ E-Cigarettes □ Alcohol □ Drugs (prescription or otherwise) □ Access to firearm(s)/weapon(s) □ Has a firearm(s)/weapon(s) secured? □ Yes □ No □ NA □ Witnessed violence/abuse □ Threatened with violence		

Is your child in school? ☐ Yes ☐ No _____

Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Favorite thing about school

Activities outside school_

Any problems?__

Social/Psychosocial History

Family relationships ☐ Good ☐ Okay ☐ Poor

monthly (food, housing, heat, etc.)? ☐ Yes ☐ No __

Do you have concerns about meeting basic family needs daily and/or

Are you and/or your partner working outside home? ☐ Yes ☐ No

What is your family living situation_

General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

ame		DOB	Age Sex: □ M □ F
Nutrition/Physical A		Anticipatory Guidance (Consult Bright Futures, Fourth Edition for further information	Plan of Care Assessment □ Well Child □ Other Diagnosis
Fruits/vegetables/lea	an protein per day		7.000000110111
□ Normal elimination	n	Social Determinants of Health	Labs
	xercise an hour most days	☐ Living situation and food security	☐ Hemoglobin/hematocrit (if high risk)
Type of physical acti	vity/exercise	□ Tobacco, alcohol, and drugs	☐ Blood lead (if not completed at 12 and/or 24 months or high risk)
Normal sleeping patt	terns? ☐ Yes ☐ No	☐ Positive family interactions	(enter into WVSIIS)
Hours of sleep each	night?	□ Work-life balance	☐ TB skin test (if high risk)
*See Periodicity Sc	hedule for Risk Factors	Playing with Siblings and Peers	□ Other
*A		☐ Play opportunities and interactive games	
□ Low risk □ High	noglobin/Hematocrit) nrisk	☐ Sibling relationships	
*Lead Risk		Encouraging Literacy Activities	Referrals
□ Low risk □ High	ı risk	Encouraging Literacy Activities	See page 1, school requirements
		☐ Reading, talking, and singing together ☐ Language development	
*Tuberculosis Risk ☐ Low risk ☐ High		□ Language development	Prior Authorizations
g		Promoting Healthy Nutrition and Physical Activity	For treatment plans requiring authorization, please complete
Dhysical Evamir	nation (N=Normal, Abn=Abnormal)	☐ Water, milk, and juice	page 3. Contact a HealthCheck Regional Program Specialist fo
General Appearance	e		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
Skin	□ N □ Abn	☐ Competence in motor skills and limits on inactivity	
Neurological	□ N □ Abn		- u u u u u u u - u
Reflexes	□ N □ Abn	Safety	Follow Up/Next Visit □ 4 years of age
Head	□ N □ Abn	☐ Car safety seats	□ Other
Neck	□ N □ Abn	☐ Choking prevention	
Eyes	□ N □ Abn	☐ Pedestrian safety and falls from windows	
Red Reflex	□ N □ Abn		☐ Screen has been reviewed and is complete
Ocular Alignment	□ N □ Abn	□ Pets	
Ears	□ N □ Abn	☐ Firearm safety	See page 1, school requirements for required signature
Nose	□ N □ Abn	-	
Oral Cavity/Throat	□ N □ Abn	□ Other	
Lung	□ N □ Abn		
Heart	□ N □ Abn	— <u> </u>	
Pulses	□ N □ Abn		
Abdomen	□ N □ Abn		
Genitalia	□ N □ Abn		
Back	□ N □ Abn		
Hips	□ N □ Abn		
Extremities	□ N □ Abn		
Possible Signs of A	Abuse □ Yes □ No		

creen Date Early and Periodic Sc					ealth and Human Resourc PSDT) HealthCheck Prog		h Screen	4 Year For
Name					DOB		Age	Sex: 🗆 M 🗆 F
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (op	tional)
Allergies □ NKDA	A	· · · · · · · · · · · · · · · · · · ·						
Current meds □ I	None							
		Child with spe				/section 504 in place		
Accompanied by	□ Parent □ Grandnare	ont □ Foster parent □ Fo	eter organization			□ Other		
Oral Health Date of last dental visit			Developmental Surveillance (✓ Check those that apply) □ Child can enter bathroom and have a bowel movement by himself/ herself □ Child can brush his/her teeth □ Child can dress and undress without much help □ Child can engage in well-developed imaginative play □ Child can answer simple questions □ Child can speak in words that are 100% understandable to strangers □ Child can draw pictures that you recognize □ Child can follow simple rules when playing games □ Child can tell you a story from a book □ Child can skip on 1 foot □ Child can climb stairs, alternating feet, without support □ Child can draw a person with at least 3 body parts			Referrals: Developmental Mental/behavioral health/trauma - Help4WV.com/1-844-435-74 Dental Dision Hearing Other Children with Special HealthCare Needs (CSHCN) 1-800-642-9704		
R L _ Wears glasses? D		JTO (retest in 6 months)	without support	Child can draw a pers		⊔ women, infants and	d Children (WIC) 1-304	-558-0030
Hearing Screen 20 db@ R ear 500H	□ UTO (retest in 6 m IZ R ear 1000HZ _	onths) 2000HZ 4000HZ	fingers instead of fis	t .	p pencil with thumb and	Please Print Name of	f Facility or Clinician	

The information above this line is intended to be released to meet school entry requirements

☐ Concerns about child's behavior, speech, learning, social or motor



School Entry Requirements

4 Year Form

Medical History □ Initial Screen □ Periodic Screen	Child care/after school care	Risk Indicators (✓ Check th
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:	How much stress are you and your family under <u>now</u> ? □ None □ Slight □ Moderate □ Severe What kind of stress? (✓ Check those that apply) □ Relationships (partner, family and/or friends) □ School/work	Child exposed to ☐ Cigarette:☐ Drugs (prescription or otherwi☐ Access to firearm(s)/weapon(Are the firearm(s)/weapon(s) sec
□ Family health history reviewed	☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of	☐ Witnessed violence/abuse☐ Scary experience that your ch
Concerns and/or questions	support/help □ Financial/money □ Emotional loss □ Health insurance □ Other	Do you utilize a car/booster seat □ Excessive television/video ga
Social/Psychosocial History What is your family living situation	Is your child in school? □ Yes □ NoFavorite thing about school	General Health ☐ Growth plotted on growth cha
Family relationships ☐ Good ☐ Okay ☐ Poor Do you have concerns about meeting basic family needs daily and/ monthly (food, housing, heat, etc.)? ☐ Yes ☐ No	Any problems? Activities outside school Peer relationships/friends □ Good □ Okay □ Poor	□ BMI calculated and plotted on
Are you and/or your partner working outside home? ☐ Yes ☐ No	_	

L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ

Wears hearing aids? ☐ Yes ☐ No

Risk Indicators (✓ Check those that apply)
Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget

for your child? ☐ Yes ☐ No me/internet/cell phone use

Signature of Clinician/Title

BMI chart



Screen Date		4 Year Form, Page 2
Name	DOB	Age Sex: □ M □ F
Nutrition/Physical Activity/Sleep Normal eating habits? ☐ Yes ☐ No Fruits/vegetables/lean protein per day ☐ Vitamins		Plan of Care Assessment □ Well Child □ Other Diagnosis
□ Normal elimination □ Physical activity/exercise an hour most days Type of physical activity/exercise Normal sleeping patterns? □ Yes □ No Hours of sleep each night? *See Periodicity Schedule for Risk Factors	Anticipatory Guidance	Labs ☐ Hemoglobin/hematocrit (if high risk) ☐ Blood lead (if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS) ☐ TB skin test (if high risk) ☐ Lipid profile (if high risk) ☐ Other
*Anemia Risk (Hemoglobin/Hematocrit) ☐ Low risk ☐ High risk	Social Determinants of Health ☐ Living situation and food security	
*Lead Risk □ Low risk □ High risk	☐ Tobacco, alcohol, and drugs ☐ Intimate partner violence	Referrals See page 1, school requirements
*Tuberculosis Risk □ Low risk □ High risk	☐ Safety in the community ☐ Engagement in the community	Prior Authorizations For treatment plans requiring authorization, please complete
*Dyslipidemia Risk □ Low risk □ High risk	School Readiness	page 3. Contact a HealthCheck Regional Program Specialist for

a con non a riigiri	ioit		
Physical Examina			
General Appearance			·
Skin	\square N	☐ Abn	
Neurological	\square N	☐ Abn	
Reflexes	\square N	☐ Abn	
Head	\square N	☐ Abn	
Neck	\square N		
Eyes	\square N	☐ Abn	
Red Reflex	\square N		
Ocular Alignment	\square N	☐ Abn	
Ears	\square N		
Nose	\square N	☐ Abn	
Oral Cavity/Throat	\square N	☐ Abn	
Lung	\square N	☐ Abn	
Heart	\square N	☐ Abn	
Pulses	\square N	☐ Abn	
Abdomen	\square N	☐ Abn	
Genitalia	\square N	☐ Abn	
Back	\square N	☐ Abn	
Hips	\square N	☐ Abn	
Extremities	\square N	☐ Abn	

Possible Signs of Abuse ☐ Yes ☐ No

Anticipatory Guidance (Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org) Social Determinants of Health Living situation and food security Tobacco, alcohol, and drugs Intimate partner violence Safety in the community Engagement in the community School Readiness Language understanding and fluency Feelings Opportunities to socialize with other children Readiness for structured learning experiences Early childhood programs and preschool Developing Healthy Nutrition and Personal Habits Milk, water, and juice Nutritious foods Daily routines that promote health Media Use Limits on use Promoting physical activity and safe play Safety Belt-positioning car booster seats Outdoor safety Water safety Sun protection Pets Firearm safety
(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org) Social Determinants of Health Living situation and food security Tobacco, alcohol, and drugs Intimate partner violence Safety in the community Engagement in the community School Readiness Language understanding and fluency Feelings Opportunities to socialize with other children Readiness for structured learning experiences Early childhood programs and preschool Developing Healthy Nutrition and Personal Habits Milk, water, and juice Nutritious foods Daily routines that promote health Media Use Limits on use Promoting physical activity and safe play Safety Belt-positioning car booster seats Outdoor safety Water safety Sun protection Pets Firearm safety
(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org) Social Determinants of Health Living situation and food security Tobacco, alcohol, and drugs Intimate partner violence Safety in the community Engagement in the community School Readiness Language understanding and fluency Feelings Opportunities to socialize with other children Readiness for structured learning experiences Early childhood programs and preschool Developing Healthy Nutrition and Personal Habits Milk, water, and juice Nutritious foods Daily routines that promote health Media Use Limits on use Promoting physical activity and safe play Safety Belt-positioning car booster seats Outdoor safety Water safety Sun protection Pets Firearm safety
(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org) Social Determinants of Health Living situation and food security Tobacco, alcohol, and drugs Intimate partner violence Safety in the community Engagement in the community School Readiness Language understanding and fluency Feelings Opportunities to socialize with other children Readiness for structured learning experiences Early childhood programs and preschool Developing Healthy Nutrition and Personal Habits Milk, water, and juice Nutritious foods Daily routines that promote health Media Use Limits on use Promoting physical activity and safe play Safety Belt-positioning car booster seats Outdoor safety Water safety Sun protection Pets Firearm safety
□ Living situation and food security □ Tobacco, alcohol, and drugs □ Intimate partner violence □ Safety in the community □ Engagement in the community □ Engagement in the community School Readiness □ Language understanding and fluency □ Feelings □ Opportunities to socialize with other children □ Readiness for structured learning experiences □ Early childhood programs and preschool Developing Healthy Nutrition and Personal Habits □ Milk, water, and juice □ Nutritious foods □ Daily routines that promote health Media Use □ Limits on use □ Promoting physical activity and safe play Safety □ Belt-positioning car booster seats □ Outdoor safety □ Water safety □ Sun protection □ Pets □ Firearm safety
□ Language understanding and fluency □ Feelings □ Opportunities to socialize with other children □ Readiness for structured learning experiences □ Early childhood programs and preschool Developing Healthy Nutrition and Personal Habits □ Milk, water, and juice □ Nutritious foods □ Daily routines that promote health Media Use □ Limits on use □ Promoting physical activity and safe play Safety □ Belt-positioning car booster seats □ Outdoor safety □ Water safety □ Sun protection □ Pets □ Firearm safety
 Milk, water, and juice Nutritious foods Daily routines that promote health Media Use Limits on use Promoting physical activity and safe play Safety Belt-positioning car booster seats Outdoor safety Water safety Sun protection Pets Firearm safety
□ Limits on use □ Promoting physical activity and safe play Safety □ Belt-positioning car booster seats □ Outdoor safety □ Water safety □ Sun protection □ Pets □ Firearm safety
□ Belt-positioning car booster seats □ Outdoor safety □ Water safety □ Sun protection □ Pets □ Firearm safety
□ Other

page 3. Contact a HealthCheck Regional Program Speci assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

Follow Up/Next Visit	☐ 5 years of age
☐ Other	

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date		Early and Periodic S			alth and Human Resourc PSDT) HealthCheck Prog		lth Screen	5 and 6 Year Forn	
Name					DOB		Age	Sex: 🗆 M 🗆 F	
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (option	nal)	
Allergies □ NKI	DA								
Current meds] None								
☐ Foster Child _		Child with sp	pecial health care needs			P/section 504 in place			
Accompanied by	/ □ Parent □ Grandpar	rent □ Foster parent □ F	oster organization						
Oral Health Date of last dental visit Current oral health problems Water source			Developmental Developmental Surveillance (✓ Check those that apply) □ Child can balances on one foot, hops and skips □ Child is able to tie a knot, has mature pencil grasp, can draw a person with at least 6 body parts, prints some letters and numbers and is able to copy squares and triangles □ Child has good articulation, tells a simple story using full sentences, uses appropriate tenses and pronouns, can count to 10, and names at least 4 colors □ Child follows simple directions, is able to listen and attend, and undresses and dresses with minimal assistance □ Concerns about child's behavior, speech, learning, social or motor skills			Immunizations: Attach current immunization record □ UTD □ Given, see immunization record □ Entered into WVSIIS Referrals: □ Developmental □ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498 □ Dental □ Vision □ Hearing □ Other □ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704 Please Print Name of Facility or Clinician Signature of Clinician/Title			
		— — — — — — — — The informati	on above this line is	 intended to be rel	eased to meet school en	try requirements			
☐ Initial Screen	Medical History ☐ Initial Screen ☐ Periodic Screen Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations: ☐ Family health history reviewed ☐ Concerns and/or questions			How much stress are you and your family under now? ☐ None ☐ Slight ☐ Moderate ☐ Severe What kind of stress? (✓ Check those that apply) ☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health Child exposed to ☐ Cig ☐ Drugs (prescription or ☐ Access to firearm(s)/weapon ☐ Witnessed violence/ab ☐ Scary experience that ☐ Do you utilize a car/boost			(✓ Check those that apply)□ Cigarettes □ E-Cigarette	es 🗆 Alcohol	
counselors and/c							Do you utilize a car/booster seat for your child? ☐ Yes ☐ No Does your child wear protective gear, including seat belts?		

Social/Psychosocial History What is your family living situation_

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _

Are you and/or your partner working outside home? ☐ Yes ☐ No

Activities outside school Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child's grade in school

Favorite subject_

Any problems?

☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart



5	Screen Date						
---	-------------	--	--	--	--	--	--

5 and 6 Year Form, Page 2

Name		DOB	
Nutrition/Physical	Activity/Sleep	Anticipatory Guidance	Plan of Care
Normal eating habits	s? □Yes □No	(Consult Bright Futures, Fourth Edition for further information	Assessment □ Well Child □ Other Diagnosis
	an protein per day	https://brightfutures.aap.org)	
☐ Vitamins		_	
☐ Normal eliminatio	on	Social Determinants of Health	Labs
	exercise an hour most days	☐ Neighborhood and family violence	☐ Hemoglobin/hematocrit (if high risk)
	tivity/exercise	□ Food security	☐ Blood lead (if not completed at 12 and/or 24 months or high risk)
	tterns? ☐ Yes ☐ No	☐ Family substance use (tobacco, alcohol, drugs)	(enter into WVSIIS)
Hours of sleep each	n night?	,	☐ TB skin test (if high risk)
*See Periodicity So	chedule for Risk Factors	☐ Connectedness with family	☐ Lipid profile (year 6, if high risk) ☐ Other
*Anomia Diek (Hon	noglobin/Hematocrit)	Developmental and Mental Health	2 6 (1) 6/1
□ Low risk □ High		☐ Family rules and routines	
		☐ Concern and respect for others	
*Lead Risk ☐ Low risk ☐ High	h rick	☐ Patience and control over anger	Referrals
L LOW IISK LI HIGI	IIIISK		See page 1, school requirements
*Tuberculosis Risk		School	Prior Authorizations
☐ Low risk ☐ High	h risk	□ Readiness	For treatment plans requiring authorization, please complete
*Dyslipidemia Risk	(year 6)	☐ Established routines and school attendance	page 3. Contact a HealthCheck Regional Program Specialist for
☐ Low risk ☐ High	h risk	Friends	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
		☐ After school care	•
Physical Exami	nation (N=Normal, Abn=Abnormal) e □ N □ Abn	□ Parent - teacher communication	
Skin	□ N □ Abn	Physical Growth and Development	Follow Up/Next Visit ☐ 6 years of age ☐ 7 years of age
Neurological	□ N □ Abn	☐ Oral health (dental visits, brushing and flossing, fluoride, limits	□ Other
Reflexes	□ N □ Abn		
Head	□ N □ Abn		☐ Screen has been reviewed and is complete
Neck	□ N □ Abn	and vitariin B intake, ricality recae in concern	D octeen has been reviewed and is complete
Eyes	□ N □ Abn	── ☐ Physical activity (60 minutes per day)	See page 1, school requirements for required signature
Ocular Alignment	□ N □ Abn		dee page 1, school requirements for required signature
Ears	□ N □ Abn		
Nose	□ N □ Abn	☐ Car safety☐ Outdoor safety	
Oral Cavity/Throat	□ N □ Abn	— Weter sefety	
Lung	□ N □ Abn		
Heart	□N □ ADN		
Pulses	□ N □ Abn	_	
Abdomen Genitalia	□ N □ Abn		
Back	□ N □ Abn	_	
Hips	□ N □ Abn	□ Other	
Extremities	□ N □ Abn		
Lxuemiles			
Possible Signs of A	Abuse □ Yes □ No		
Concerns and/or qu	estions		

Screen Date Early and Periodic					ealth and Human Resourc PSDT) HealthCheck Prog		Ith Screen	7 and 8 Year Form	
Name		• 	<u> </u>	•	,			Sex: 🗆 M 🗆 F	
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional)	
Allergies □ NKD	DA					· · · · · · · · · · · · · · · · · · ·			
Current meds □] None								
☐ Foster Child _		Child with sp	ecial health care need	ds	D IE	P/section 504 in place			
Accompanied by	/ □ Parent □ Grandp	arent □ Foster parent □ F	oster organization						
Immunizations: Attach current immunization record □ UTD □ Given, see immunization record □ Entered into WVSIIS Oral Health Date of last dental visit Current oral health problems Water source □ Public □ Well □ Tested Fluoride supplementation □ Yes □ No Vision Acuity Screen: R L Wears glasses? □ Yes □ No No			L ear 500HZ Wears hearing aids Developmental Concerns about belskills	L ear1000HZ Pes No Surveillance havior, speech, learnir	1-800-642-9704 arning, social or motor			s (CSHCN)	
		The information	above this line is in	ntended to be releas	sed to meet school entry i	requirements			
Medical History □ Initial Screen □ Periodic Screen Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations: □ Family health history reviewed □ Concerns and/or questions			How much stress are you and your family under <u>now</u> ? □ None □ Slight □ Moderate □ Severe What kind of stress? (✓ Check those that apply) □ Relationships (partner, family and/or friends) □ School/work □ Child care □ Drugs □ Alcohol □ Violence/abuse (physical, emotional and/or sexual) □ Family member incarcerated □ Lack of support/help □ Financial/money □ Emotional loss □ Health insurance □ Other_			□ Witnessed violence/abuse □ Threatened with violence/abuse □ Scary experience that your child cannot forget □ Does your child wear protective gear, including seat belts? □ Yes □ No □ Expensive television wides game/interpet/cell phage use			
						☐ Growth plotted on growth chart ☐ BMI calculated and plotted on BMI chart			
What is your fam		ПРоог	Favorite subject Any problems? Activities outside so	 		Nutrition/Physical Normal eating habits Fruits/vegetables/lea	Activity/Sleep s? □ Yes □ No		
Family relationships ☐ Good ☐ Okay ☐ Poor Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No				(✓ <i>Check those that a</i>		□ Normal elimination □ Physical activity/exercise an hour most days Type of physical activity/exercise			

Exposure to □ Cigarettes □ E-Cigarettes □ Alcohol

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Has a firearm(s)/weapon(s)

☐ Drugs (prescription or otherwise)

☐ Access to firearm(s)/weapon(s)

Are parents/caregivers working outside home? ☐ Yes ☐ No

Child care/after school care

Continue on page 2

Hours of sleep each night?_

Normal sleeping patterns? ☐ Yes ☐ No



Screen	Date		

7 and 8 Year Form, Page 2

Name	DOB	Age Sex: □ M □ F
*See Periodicity Schedule for Risk Factors *Anemia Risk (Hemoglobin/Hematocrit) □ Low risk □ High risk	Anticipatory Guidance (Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)	Plan of Care Assessment □ Well Child □ Other Diagnosis
*Tuberculosis Risk Low risk High risk *Dyslipidemia Risk Low risk High risk Physical Examination (N=Normal, Abn=Abnormal) General Appearance N Abn Skin N Abn	Social Determinants of Health Neighborhood and family violence (bullying, fighting) Food security Family substance use (tobacco, e-cigarettes, alcohol, drugs) Harm from the internet Emotional security and self-esteem Connectedness with family and peers	Labs ☐ Hemoglobin/hematocrit (if high risk) ☐ TB skin test (if high risk) ☐ Lipid profile (if high risk) ☐ Other
Neurological	conflict resolution □ Puberty and pubertal development School □ Adaption to school, school problems (behavior or learning issues), school performance and progress, school attendance, individual education program or special education services, involvement in school activities and after-school programs Physical Growth and Development □ Oral health (dental visits, brushing and flossing, fluoride, limits	Referrals See page 1, school requirements Prior Authorizations For treatment plans requiring authorization, please complet page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck Follow Up/Next Visit

Screen Date		Early and Periodic S	West Virginia De Screening, Diagnosis, an		alth and Human Resourd PSDT) HealthCheck Prog		th Screen	and 10 Year Form
Name					DOB		Age	Sex: □ M □ F
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional	()
Allergies □ NKD	Α			· · · · · · · · · · · · · · · · · · ·				
Current meds □	None							
						EP/section 504 in place_		
Accompanied by	☐ Parent ☐ Grandpar	rent □ Foster parent □	Foster organization			Dother		
counselors and/or	☐ Periodic screen urgeries, illnesses, visits r hospitalizations: history reviewed		sexual) ☐ Family memb	floderate ☐ Seve ✓ Check those that r, family and/or fri Violence/abuse (poer incarcerated I al loss ☐ Health	ere at apply) ends) □ School/work ohysical, emotional and/or □ Lack of support/help	☐ Vitamins ☐ Normal eliminatior☐ Physical activity/e. Type of physical activ Normal sleeping patt	? □ Yes □ No n protein per day	
Concerns and/or o	questions					riodis of sleep each	ingit:	
	osocial History ly living situation		Traumatic Stress Reac *Positive screen = nun	nbered response		Current oral health p	sit roblems blic	
Do you have cond monthly (food, hou	Family relationships Good Okay Poor Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? Yes No Are parents/caregivers working outside home? Yes No		Repeated, disturbing me stressful experience from Moderately(2) Qu Feeling very upset when	ot at all □ A little bit(1) tremely(4) ded you of a stressful		n: (Objective 10 years)		
	chool care		experience from the <u>pas</u>		. ,	Hearing Screen (Ob		
Any problems? Activities outside s Peer relationships		ay □ Poor	Exposure to ☐ Cigare ☐ Drugs (prescription or ☐ Access to firearm(s)/w	ttes □ E-Cigaret rotherwise) weapon(s) □ on(s) secured? □	tes	20db@ R ear: 500Hz L ear: 500Hz Wears hearing aids? *See Periodicity Sc.	Z 1000HZ 2000HZ Z 1000HZ 2000HZ □ Yes □ No hedule for Risk Factors	Z 4000HZ Z 4000HZ
skills			☐ Witnessed violence/a	buse ☐ Thre	atened with violence/abuse	Anemia Risk (Hem	oglobin/Hematocrit)	

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA Do you wear protective gear, including seat belts? ☐ Yes ☐ No

 $\hfill\square$ Excessive television/video game/internet/cell phone use

□ Low risk □ High risk

*Tuberculosis Risk

☐ Low risk ☐ High risk

*Dyslipidemia Risk

☐ Low risk ☐ High risk

Fasting lipoprotein required once between 9 and 11 years

Continue on page 2



General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

Concerns about moodiness or depression

ame		DOB	Age Sex: □ M □ F
Physical Examin General Appearance	nation (N=Normal, Abn=Abnormal) e □ N □ Abn	Anticipatory Guidance (Consult Bright Futures, Fourth Edition for further information	Plan of Care Assessment □ Well Child □ Other Diagnosis
Skin	□ N □ Abn	https://brightfutures.aap.org)	
Neurological	□ N □ Abn	_	Immunizations
Reflexes	□ N □ Abn	Social Determinants of Health	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Head	□ N □ Abn	☐ Neighborhood and family violence (fighting, bullying)	
Neck	□ N □ Abn	☐ Food security	Labs
Eyes	□ N □ Abn	☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)	☐ Hemoglobin/hematocrit (if high risk)
Ears	□ N □ Abn	☐ Harm from the internet	☐ TB skin test (if high risk)
Nose	□ N □ Abn	☐ Emotional security and self esteem	☐ Fasting lipoprotein (once between 9 and 11 years and/or high
Oral Cavity/Throat	□ N □ Abn	☐ Connectedness with family and peers	risk)
Lung	□ N □ Abn		□ Other
Heart	□ N □ Abn	Development and Mental Health	
Pulses	□ N □ Abn		
Abdomen	□ N □ Abn	☐ Sexuality (pubertal onset, personal hygiene, initiation of growth	
If female: LMP	□ Regular □ Irregular	spurt, menstruation and ejaculation, loss of baby fat and accretion of muscles, sexual safety)	Referrals Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
Bleeding	□ Normal □ Heavy	Onland	□ Dental □ Vision □ Hearing
Cramping	□ No □ Slight □ Severe	School	□ Other
Genitalia	□ N □ Abn	☐ School attendance, school problems (behavior or learning),	
Back	□ N □ Abn	school performance and progress, transitions, co-occurrence of middle school and pubertal transactions	Children with Chariel Health Care Needs (CCHCN)
Hips	□ N □ Abn	— middle school and pubertal transactions	☐ Children with Special HealthCare Needs (CSHCN)
Extremities	□ N □ Abn	Physical and Growth Development	1-800-642-9704
•	Abuse □ Yes □ No	☐ Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)	Prior Authorizations
Concerns and/or qu	estions	□ Nutrition (healthy weight, disordered eating behaviors, importance of breakfast, limits on saturated fat and added sugars, healthy snacks)	For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
		☐ Physical activity (60 minutes per day, after school activities)	3
		Safety	Follow Up/Next Visit □ 10 years of age □ 11 years of age
		☐ Car safety	□ Other
		☐ Safety during physical activity	
		☐ Water safety	☐ Screen has been reviewed and is complete
		□ Sun protection	
		☐ Knowing child's friends and their families	
		□ Firearm safety	
		— — — — — — — — — — — — — — — — — — —	

Please Print Name of Facility or Clinician

Signature of Clinician/Title

Screen Date	· · · · · · · · · · · · · · · · · · ·		creening, Diagnosis,	and Treatment (EP		gram Preventive Hea	Ith Screen	and 14 Year Form	
Name							Age		
Weight	_ Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional)	<u> </u>	
Allergies ☐ NKDA									
Current meds ☐ None_							 		
☐ Foster Child		Child with sp	pecial health care needs	3	D IE	P/section 504 in place_			
Accompanied by ☐ Par	irent □ Grandpare	ent □ Foster parent □ F	oster organization						
Oral Health Date of last dental visit_ Current oral health prob Water source □ Public Fluoride supplementatio	olems C □ Well □ Teste	d □ Entered into WVSIIS	20db@ R ear: 500Hz L ear: 500Hz R ear: 6000H L ear: 6000H Wears hearing aids?	IZ 8000HZ □ Yes □ No urveillance	000HZ 4000HZ 000HZ 4000HZ	□ Substance abuse □ Dental □ Vision □ Other □ Family Planning (I □ Children with Spe 1-800-642-9704	health/trauma - Help4WV.com - Help4WV.com/1-844-435-749: Hearing FP) 1-800-642-9704 cial HealthCare Needs (CSHC	8 5	
R	Vision Acuity Screen: (Objective 12 years) R L Nears glasses? □ Yes □ No			Concerns about behavior, speech, learning, social and/or motor skills			Signature of Clinician/Title		
		The information	above this line is in	tended to be releas	ed to meet school ent	ry requirements		>	
		to other providers and/or	How much stress are □ None □ Slight □	ends □ Good □ Okay e you and your family u □ Moderate □ Severe ? (✓ Check those that	nder <u>now</u> ?	*Positive screen = I *If Positive see Per Feelings over the p	I/Patient Health Questionnair numbered responses 3 or gra iodicity Schedule for link to last 2 weeks: (✓ Check one for sure in doing things: □ Not at a	eater PHQ-9 or each question)	
☐ Family health histor	ry reviewed			tner, family and/or frier ☐ Violence/abuse (ph	ds) □ School/work /sical, emotional and/or		days(2) ☐ Nearly every day(3 essed, or hopeless: ☐ Not at	•	
Concerns and/or question	ons		sexual) □ Family me	ember incarcerated ☐ ional loss ☐ Health in	Lack of support/help	☐ More than ½ the o	days(2)	, ,	
Social/Psychosocia	ial History					- None identified F	(√ Check those that apply)] *Tobacco use □ Cigarettes ‡	# per dav	
What is your family living	-	····	Concerns and/or que	stions	· · · · · · · · · · · · · · · · · · ·	□ E-Cigarettes □ *0	Chew ☐ Passive Smoke Risk		
Family relationships □ Good □ Okay □ Poor Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No			*If positive see Periodicity *Positive screen = numbered responses 4 or greater Feelings over the past 2 weeks: (< Check one for each question)			Drug use (prescription or otherwise) oositive see Periodicity Schedule for links to CRAFFT /or SBIRT screening tools ccess to firearm(s)/weapon(s) □ Has a firearm(s)/weapon(s)			
Are parents/caregivers v	working outside ho	me? □ Yes □ No	repeated, disturbing	memories, thoughts, o	i images of a	Are the firearm(s)/we	eapon(s) secured? Yes	I No □ NA	

stressful experience from the **past**? \square Not at all \square A little bit(1)

Feeling very upset when something reminded you of a stressful

 \square Moderately(2) \square Quite a bit(3) \square Extremely(4)

 \square Moderately(2) \square Quite a bit(3) \square Extremely(4)

experience from the **past**? \square Not at all \square A little bit(1)

Continue on page 2



Child care/after school care

Grade in school

Favorite subject

Activities outside school

Any problems

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Do you wear protective gear, including seat belts? ☐ Yes ☐ No

Screen Date			11, 12, 13 and 14 Year Form, Pa
Name		DOB	Age Sex: □ M □
☐ Excessive television/video game/internet/cell phone use	Oral Cavity/Throat	□ N □ Abn	Safety
	Lung	□ N □ Abn	☐ Seat belt and helmet use
(13 and 14 years)	Heart	□ N □ Abn	☐ Substance use and riding in a vehicle
Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No	Pulses	□ N □ Abn	☐ Firearm safety
Are you sexually active? ☐ Yes ☐ No	Abdomen	□ N □ Abn	
Method of contraception	If female:		□ Other
Do you have children? ☐ Yes ☐ No	LMP	□ Regular □ Irregular	
	Bleeding	□ Normal □ Heavy	
	Cramping	☐ No ☐ Slight ☐ Severe	
General Health	Genitalia	□ N □ Abn	
☐ Growth plotted on growth chart	Back	□ N □ Abn	Plan of Care
☐ BMI calculated and plotted on BMI chart	Hips	□ N □ Abn	Assessment □ Well Child □ Other Diagnosis
·	Extremities	□ N □ Abn	Assessment in their office in office blughosis
Nutrition/Physical Activity/Sleep			Labs
Normal eating habits? ☐ Yes ☐ No	Possible Signs of	Abuse □ Yes □ No	☐ Hemoglobin/hematocrit (if high risk)
Fruits/vegetables/lean protein per day	Concerns and/or questions		☐ TB skin test (if high risk)
□ Vitamins	·		☐ Fasting lipoprotein (once between 9 and 11 years and/or high
☐ Normal elimination			risk)
☐ Physical activity/exercise an hour most days			☐ STI test (if sexually active and/or high risk)
Type of physical activity/exercise	Anticipatory Gu	idance	☐ STI test (if sexually active and/or high risk)
Normal sleeping patterns? ☐ Yes ☐ No	•	res, Fourth Edition for further information	,
Hours of sleep each night?	https://brightfutures.		□ Other
*See Periodicity Schedule for Risk Factors	Social Determinan	ts of Health	Referrals
*Amounts Diele (House elektrillements enth)		ence (fighting, bullying)	See page 1, school requirements
*Anemia Risk (Hemoglobin/Hematocrit) □ Low risk □ High risk	☐ Living situation ar	(0 0)) ()	See page 1, school requirements
L LOW HOR LITTINGHT HOR		use (tobacco, e-cigarettes, alcohol, drugs)	Prior Authorizations
*Tuberculosis Risk	•	vith family and peers	For treatment plans requiring authorization, please comp
☐ Low risk ☐ High risk	☐ Connectedness v	· · · · · · · · · · · · · · · · · · ·	page 3. Contact a HealthCheck Regional Program Specialis
*Dyslipidemia Risk	☐ School performar	•	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
□ Low risk □ High risk		s and decision making	assistance at 1-000-042-9704 of unin.wv.gov/neathcheck
Fasting lipoprotein required once between 9 and 11 years	Li Coping with sites	s and decision making	
*STI Risk	•	d Health Promotion	Follow Up/Next Visit ☐ 12 years of age ☐ 13 years of age
☐ Low risk ☐ High risk	☐ Oral health		☐ 14 years of age
*LIN/ Di-I-	☐ Body image		□ Other
*HIV Risk □ Low risk □ High risk	☐ Healthy eating		
L LOW HOR LITTINGH HOR	☐ Physical activity a	and sleep	
Physical Examination (N=Normal, Abn=Abnormal)			☐ Screen has been reviewed and is complete

Emotional Well-being

□ Sexuality

drugs

Risk Reduction

☐ Acoustic trauma

☐ Mood regulation and mental health

☐ Pregnancy and sexually transmitted infections

☐ Tobacco, e-cigarettes, alcohol, prescription drugs or street

General Appearance

N

Abn ______

Skin

Head

Neck

Eyes

Ears

Nose

Neurological

Reflexes

□ N □ Abn _____

□ N □ Abn

WEST WINGINA
Department of
Health
Health
Resources

See page 1, school requirements for required signature

Screen Date		Early and Periodic S	West Virgini creening, Diagnosis	a Department of He s, and Treatment (E	ealth and Human Resou PSDT) HealthCheck Pro	rces ogram Preventive Hea	19 Ith Screen	5, 16 and 17 Yea	r Form	
Name					DOB			Sex: □ M	ΠF	
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (opti	onal)		
Allergies □ NKD)A									
Current meds □	None									
		Child with sp				☐ IEP/section 504 in place	e	1		
Accompanied by	□ N/A □ Parent □ G	randparent	nt □ Foster organiza	tion		□ Othe	er			
□ UTD □ Given Oral Health	,	rd ☐ Entered into WVSIIS	20db@ R ear: 500H		en 15 and 17 years) _2000HZ 4000HZ _2000HZ 4000HZ	☐ Substance abuse ☐ Dental ☐ Vision	•		498	
Date of last dental visit			R ear: 6000 L ear: 6000 Wears hearing aids'	HZ 8000HZ		☐ Other ☐ Family Planning (FP) 1-800-642-9704 ☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704				
Vision Acuity Screen: (Objective 15 years) R L Wears glasses? □ Yes □ No					ng, social and/or motor					
						Signature of Clinician/Title				
		The information	above this line is i	ntended to be relea	ased to meet school en	try requirements			<i>></i>	
counselors and/or	☐ Periodic screen urgeries, illnesses, visits r hospitalizations:		□ None □ Slight What kind of stress □ Relationships (pa □ Drugs □ Alcohol	☐ Violence/abuse (ere at apply) iends) □ School/work ohysical, emotional and/or	*Positive screen = *If Positive see Per Feelings over the p Little interest or plea	n/Patient Health Question numbered responses 3 or riodicity Schedule for lin past 2 weeks: (✓ Check or past in doing things: □ Nor days(2) □ Nearly every or	or greater k to PHQ-9 ne for each quest ot at all □ Severa	,	
☐ Family health	history reviewed		☐ Financial ☐ Emotional loss ☐ Health insurance Feeling of				essed, or hopeless: DN	ot at all □ Sever	al days(
Concerns and/or	questions		☐ Other			_ ☐ More than ½ the o	days(2) ☐ Nearly every	day(3)		
•	osocial History		Concerns and/or qu	estions		 ─ □ None identified □ 	(✓ <i>Check those that appl</i> y] *Tobacco use □ Cigare	ttes # per day		
What is your living	g situation?		Traumatic Stress F			☐ E-Cigarettes ☐ * ☐ *Alcohol use_	Chew ☐ Passive Smoke	Risk		
Do you have cond	Family relationships □ Good □ Okay □ Poor Do you have concerns about your family meeting basic needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No			*Positive screen = numbered responses 4 or greater Feelings over the past 2 weeks: (✓ Check one for each question) Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? □ Not at all □ A little bit(1)			and /or SBIRT screening tools			
Are you still in sch	hool? □ Yes □ No W	orking? □ Yes □ No	I I Moderately(2) I (Quite a bit(3) I Extremely(4)				eapon(s) secured? ☐ Ye	es 🗆 No 🗆 NA	, ,	

experience from the **past**? ☐ Not at all ☐ A little bit(1)

 \square Moderately(2) \square Quite a bit(3) \square Extremely(4)

Continue on page 2



What are your future plans?

What interests do you have outside of school and/or work?

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Screen Date			15, 16 and 17 Year Form, Page 2
Name		DOB	Age Sex: □ M □ F
Do you wear protective gear, including seat belts? ☐ Yes ☐ No	Nose	□ N □ Abn	Safety
☐ Excessive television/video game/internet/cell phone use	Oral Cavity/Throat	□ N □ Abn	
	Lung	□ N □ Abn	□ Driving
Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No	Heart	□ N □ Abn	□ Sun protection
Are you sexually active? ☐ Yes ☐ No	Pulses	□ N □ Abn	☐ Firearm safety
Method of contraception	Abdomen	□ N □ Abn	
Do you have children? ☐ Yes ☐ No	If female:		□ Other
	LMP	□ Regular □ Irregular	
	Bleeding	□ Normal □ Heavy	
General Health	Cramping	□ No □ Slight □ Severe	
☐ Growth plotted on growth chart	Genitalia	□ N □ Abn	

□ N □ Abn _____

□ N □ Abn _____

□ N □ Abn _____

Back

Hips

Extremities

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Concerns and/or questions

Social Determinants of Health

☐ Interpersonal violence (fighting, bullying)

Possible Signs of Abuse ☐ Yes ☐ No

- ☐ Living situation and food security
- ☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)
- ☐ Connectedness with family and peers
- ☐ Connectedness with community
- ☐ School/work performance
- ☐ Coping with stress and decision making

☐ Low risk ☐ High risk **Physical Health and Health Promotion**

*HIV Risk

*STI Risk

□ Vitamins

☐ Low risk ☐ High risk

*Tuberculosis Risk

*Dyslipidemia Risk

HIV test required once between 15 and 18 years

☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No Fruits/vegetables/lean protein per day

□ Normal elimination

Hours of sleep each night?

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)

Type of physical activity/exercise Normal sleeping patterns? ☐ Yes ☐ No

☐ Physical activity/exercise an hour most days

Physical Examination (N=Normal, Abn=Abnormal)

General Appearance	\square N	☐ Abn	
Skin	\square N	☐ Abn	
Neurological	\square N	☐ Abn	
Reflexes			
Head	\square N		
Neck	\square N		
Eyes	\square N		
Ears	\square N	☐ Abn	

Fasting lipoprotein required once between 17 and 20 years

Emotional	Well-being

☐ Physical activity and sleep

☐ Mood regulation and mental health

□ Sexuality

☐ Oral health

☐ Body image

☐ Healthy eating

Risk Reduction

☐ Pregnancy and sexually transmitted infections

☐ Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs

☐ Acoustic trauma

Plan of Care Assessment ☐ Well Child ☐ Other Diagnosis Labs ☐ Hemoglobin/hematocrit (*if high risk*) ☐ TB skin test (if high risk) ☐ Fasting lipoprotein (once between 17 and 20 years and/or high

Referrals

or high risk)

See page 1, school requirements

☐ STI test (if sexually active and/or high risk)

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck

☐ HIV test (once between 15 and 18 years, if sexually active and/

□ Other ____

Follow Up/Next Visit 🗆 16 years of age	□ 17 years of age
☐ Other	

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date			creening, Diagnosis	s, and Treatment (E	ealth and Human Resourc PSDT) HealthCheck Prog	gram Preventive Health	Screen	, 19 and 20 Year Forr	
								Sex: □ M □ F	
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (option	nal)	
Allergies □ NKI	DA								
Current meds E	☐ None								
☐ Child with spe	ecial health care needs				□ IEP/section 504 in p	place			
Accompanied by	y □ N/A □ Parent □ 0	Grandparent □ Other							
Medical History ☐ Initial Screen ☐ Periodic screen Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:			Traumatic Stress Reactions/PCL-C¹ *Positive screen = numbered responses 4 or greater Feelings over the past 2 weeks: (✓ Check one for each question) Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? □ Not at all □ A little bit(1)			Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No Are you sexually active? ☐ Yes ☐ No Method of contraception Do you have children? ☐ Yes ☐ No			
☐ Family health history reviewed Concerns and/or questions			□ Moderately(2) □ Quite a bit(3) □ Extremely(4) Feeling very upset when something reminded you of a stressful experience from the <u>past</u> ? □ Not at all □ A little bit(1) □ Moderately(2) □ Quite a bit(3) □ Extremely(4)			General Health ☐ Growth plotted on gro ☐ BMI calculated and pl			
Social/Psychosocial History What is your living situation			Depression Screen/Patient Health Questionnaire (PHQ-2) *Positive screen = numbered responses 3 or greater *If Positive see Periodicity Schedule for link to PHQ-9 Feelings over the past 2 weeks: (Check one for each question)			Nutrition/Physical Activity/Sleep Normal eating habits? □ Yes □ No Fruits/vegetables/lean protein per day □ Vitamins			
	ol? ☐ No ☐ High schoo		П О(4)	asure in doing things: ☐ More than ½ t		□ Normal elimination			
working? ☐ Yes What are your fu	Norking? □ Yes □ No What are your future plans?			(3)	, ,	☐ Physical activity/exerce Type of physical activity/	•		
What interests do you have outside of school and/or work?			Feeling down, depressed, or hopeless: \(\subseteq \text{Not at all} \) Normal slee			Normal sleeping patterns	lormal sleeping patterns? ☐ Yes ☐ No lours of sleep each night?		
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No			Risk Indicators (✓ Check those that apply) □ None identified □ *Tobacco use □ Cigarettes # per day			Oral Health Date of last dental visit Current oral health problems			
How much stress are you and your family under now ?			☐ E-Cigarettes ☐ *Chew ☐ Passive Smoke Risk			Carron oral notice problems			

male) □ No Vision Acuity Screen: (Subjective 18-20 years) Wears glasses? ☐ Yes ☐ No Hearing Screen (Objective once between 18 and 20 years) 20db@ R ear: 500HZ 1000HZ 2000HZ 4000HZ 500HZ 1000HZ 2000HZ 4000HZ R ear: 6000HZ 8000HZ

Continue on page 2

L ear: _____ 6000HZ ____ 8000HZ Wears hearing aids? ☐ Yes ☐ No



□ *Alcohol use

□ *Drug use (prescription or otherwise)

and /or SBIRT screening tools

☐ Witnessed violence/abuse

☐ Access to firearm(s)/weapon(s)

*If positive see Periodicity Schedule for links to CRAFFT

Are the firearm(s)/weapon(s) secured? \square Yes \square No \square NA

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Do you wear protective gear, including seat belts? ☐ Yes ☐ No ☐ Excessive television/video game/internet/cell phone use

☐ Has a firearm(s)/weapon(s)

☐ Threatened with violence/abuse

How much **stress** are you and your family under **now**?

☐ Relationships (partner, family and/or friends) ☐ School/work

sexual) ☐ Family member incarcerated ☐ Lack of support/help

☐ Financial/money ☐ Emotional loss ☐ Health insurance

☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or

□ None □ Slight □ Moderate □ Severe

□ Other

Concerns and/or questions

What kind of stress? (✓ Check those that apply)

Screen Date		

18, 19 and 20 Year Form, Page 2

Name		DOB	Age Sex: 🗆 M 🔘 F
*See Periodicity S	Schedule for Risk Factors	Anticipatory Guidance	Plan of Care
*Anemia Risk (He □ Low risk □ Hig	moglobin/Hematocrit) ah risk	(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)	Assessment □ Well Child □ Other Diagnosis
			Immunizations
*Tuberculosis Ris		Social Determinants of Health	□ UTD □ Given, see immunization record □ Entered into WVSIIS
		☐ Interpersonal violence	Laba
*Dyslipidemia Ris ☐ Low risk ☐ High		☐ Living situation and food security	Labs
	in required once between 17 and 20 years	☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs) ☐ Connectedness with family and peers	☐ Hemoglobin/hematocrit (<i>if high risk</i>) ☐ TB skin test (<i>if high risk</i>)
•	.,	☐ Connectedness with ranning and peers	☐ Fasting lipoprotein (once between 17 and 20 years and/or high
*STI Risk □ Low risk □ Hig	ab rick	□ School/work performance	risk)
п гом нак п ні	gii iisk	☐ Coping with stress and decision making	☐ STI test (if sexually active and/or high risk)
*HIV Risk			☐ HIV test (once between 15 and 18 years, if sexually active and
☐ Low risk ☐ Hiç	•	Physical Health and Health Promotion	or high risk)
HIV test required	once between 15 and 18 years	☐ Oral health	□ Other
		☐ Body image	
Physical Exam	ination (N=Normal, Abn=Abnormal)	☐ Healthy eating	
	ce	☐ Physical activity and sleep	Referrals
Skin	□ N □ Abn	☐ Transition to adult care	☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
Neurological	□ N □ Abn		☐ Substance abuse - Help4WV.com/1-844-435-7498
Reflexes Head	□ N □ Abn	Emotional Well-being	☐ Dental ☐ Vision ☐ Hearing
Neck	□ N □ Abn	☐ Mood regulation and mental health	□ Other
Eyes	□ N □ Abn	□ Sexuality	
Ears	□ N □ Abn	Diele De desetion	T Family Diamin (FD) 4 000 040 0704
Nose	□ N □ Abn	Risk Reduction	☐ Family Planning (FP) 1-800-642-9704
Oral Cavity/Throat		☐ Pregnancy and sexually transmitted infections ☐ Tobacco, e-cigarettes, alcohol, prescription drugs or street	☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704
Lung	□ N □ Abn	drugs	☐ Transition to adult-oriented health care/medical home
Heart	□ N □ Abn	□ Acoustic trauma	Transition to addit-oriented health care/medical nome
Pulses	□ N □ Abn	1 / toodsto tradita	Prior Authorizations
Abdomen	□ N □ Abn	Safety	For treatment plans requiring authorization, please complete
If female:		☐ Seat belt and helmet use	page 3. Contact a HealthCheck Regional Program Specialist for
LMP	□ Regular □ Irregular	☐ Driving and substance use	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck
Bleeding	□ Normal □ Heavy	☐ Sun protection	
Cramping	☐ No ☐ Slight ☐ Severe	☐ Firearm safety	Follow Up/Next Visit ☐ 19 years of age ☐ 20 years of age
Genitalia	□ N □ Abn		□ Other
Back	□ N □ Abn	□ Other	
Hips	□ N □ Abn		☐ Screen has been reviewed and is complete
Extremities	□ N □ Abn		
Possible Signs of	Abuse □ Yes □ No		
Concerns and/or q			
			Please Print Name of Facility or Clinician
			Signature of Clinician/Title
			WEST VRIGINA